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No.

In The

Supreme Court of the United States

October Term, 1996

RAFAEL SANJUAN, M.D.and
MARCELLO A. MAVIGLIA, M.D,

Petitioner(s)

vs.

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC., and

STEPHEN C. SCHEIBER, M.D.,

Respondent(s).

Petition for Writ of Certiorari To The United States Court of Appeals for the Second Circuit

APPENDIX

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Appendix A

ABPN PART II EXAMINATION APPEAL

Marcello A. Maviglia, M.D.
JANUARY 7, 1991

I begin this appeal by stating that I do not believe that there is valid evidence or documentation to substantiate failure of the patient interview. This belief is based on the facts that I received adverse treatment from the examiners and that I passed the videotape segment which required demonstration of similar clinical skills and judgement. Regarding the latter fact, it is reported that there is consistently high degree of concordance, averaging 82 to 85 percent, between the "live patient' hour grade and the videotape hour grade. According to this premise I would have had to display radically opposing degrees of competency between the two hours, which I did not.

I shall proceed to review for you all aspects of my involvement as a candidate in the Part II examination process beginning with exam preparation followed by synopsis of both the patient and videotape segments, issues and concerns, and concluding statements.

Exam Preparation

In addition to many months of studying psychiatric text such as *The Clinical Interview Using DSM-III-R*, Othmer and Othmer, I participated in the following Board review courses:

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Exam Preparation

In addition to many months of studying psychiatric text such as *The Clinical Interview Using DSM-III-R*, Othmer and Othmer, I participated in the following Board review courses:

1. McLean Hospital Comprehensive Review and Update in Neurology; March 10-12, 1989;

2. McLean Hospital Comprehensive Review and Update in Psychiatry; March 17-19, 1989;

3. NYU/Bellevue Hospital Center Psychiatry Board Review; March 2-4, 1990;

4. Yale University School of Medicine Comprehensive Review of Psychiatry and Neurology; September 13-16, 1990; and

5. NYU/Bellevue Psychiatric Society Part II Board Review Course; October 6, 1990.

Over the course of many months I conscientiously and consistently applied the interviewing techniques and other examination criteria taught in these courses and text to the patients and clients I treated on a daily basis. Additionally, over a four month period immediately proceeding the examination worked with a mental health professional on a semi-weekly basis in role-playing patient interviews based on case histories of persons currently receiving psychiatric services. The role-playing was designed to stimulate examination conditions and accordingly observed time limits in the interviewing process. The feedback I received from these sessions enabled me to correct weaknesses and recognize strengths which could be applied during the actual exam.

These activities allowed me to approach the examination with sharp interviewing, assessment, and diagnostic skills, and with less anxiety knowing that I had

made and met a serious commitment to exam preparation.

Patient Interview

The outline that follows, represents a compendium of the case relating to the patient who was examined by this doctor during the Part II examination. I emphasize that it does not cover minute details of the examination process, since its intent is, mainly, to show that my approach to the evaluation of the gentleman who happened to be my patient, was based on humaneness, careful appraisal of the symptomatology, judicious formulation of the diagnosis and consequential and appropriate conceptualizing of a treatment plan.

At the very beginning of the interview, I spent time establishing rapport with the patient. I introduced myself, I made sure that the seating arrangement was appropriate, and then I initiated the interview by making sure that he understood the purpose of it. I advised him that, because of the short amount of time available for the evaluation, there was a chance that the pace of the interview could increase. My concern, throughout the process, was that he would feel comfortable and would leave the interview with the feeling of having been exploited.

In terms of elaboration about his symptomatology, he appeared to be somewhat hesitant and reluctant in reporting it in a comprehensive fashion. However, he gave hints that his problems included substance dependence, probably multiple, and an affective diathesis, since his current pharmacotherapy was based on lithium and stelazine. I checked about symptoms of psychosis, functional and organic; of Bipolar Type I and Type II; of

dysthmia; and of personality disorders. I questioned him regarding suicide attempts and thoughts. My intuition told me that with this particular patient it was extremely important to asses the degree of substance dependence along with the remaining aspects of his pathology.

The exploration of his family history revealed the existence of substance dependence in the psychopathological make-up of his father, who seemed to be an individual prone to temper tantrums. Upon exploration of characterologic traits, he did not volunteer much information, although some explosive traits came across. Both his insight and judgment did not seem fully appropriate, since when he talked about his future plans he seemed not to consider the impact of his pathology on his life. However, I wish I had more time to address these two categories.

As stated above, my exploration of the patient's symptomatology included the sphere of affective diathesis, of functional and/or organic pathology, and of substance dependence. The above pathological categories were included in my careful formulation of Axis I. I felt that, although there were reasons to suspect a personality disturbance due to the patient's explosive characteristics and possible substance dependence. I lacked the necessary information to corroborate an Axis II diagnosis.

My treatment plan was reflective of my formulation as I broke it down according to the different diagnostic entities. I, in fact, stated that the patient needed follow-up for both the mental and dependence problems. In terms of enhancing his compliance with pharmacologic therapy, I stressed an educational approach, and I brought up the

issue of involving the family in the treatment process since there were signs of dysfunction within the family unit. The involvement of the family, I stated, would also help in the assessment of substance abuse and/or dependence and possible issues of "co-dependence". I also brought up the possibility of involving the patient in a twelve steps program.

As I stated above, my purpose for writing about the case I was assigned was to demonstrate that I faced the exam with a "thinking mind" and methodical approach and with extreme respect for my patient, all of which are essential qualities not only to pass the Board but also to be a true man of science.

Videotape

Since I passed this segment of the examination I will only comment that I approached this segment with the same seriousness and style of data gathering and presentation as I did the patient interview segment.

Issues/Concerns

1. I offer the following as examples of inappropriate interactions on part of the examiners during the patient interview segment:

A. Overall, questions were posed to me by the examiners in a hostile and snide manner. For example, when I stated that I would educate the patient regarding the critical importance of medication (lithium) compliance, one of the examiners interrupted by saying, "Well, the patient told you he was going to take the medication didn't

he?". While the patient did say that he was taking his medication, medical literature supports continued education of patients regarding compliance. In this particular case I refer you to the article, Lithium Noncompliance, E. Shaw, *Psychiatric Annals*, 16, 583-587, 1986.

B. At one point in the interview the patient turned to the examiner and asked what was expected of him. The examiner proceeded to answer the patient rather than referring the question to me. Although I was able to establish a relationship with the patient, the examiner's response was disruptive. If it is the examiner s role to explain the process to the patient, it should have occurred prior to my entrance into the room.

2. I take issue with the fact that two seemingly inexperienced examiners were coupled for this segment. There was a palpable difference in style, attitude and temperament between the inexperienced examiners and the experienced examiners of the videotape segment, with the latter appearing to be more comfortable with their role as examiners. The issue in this situation with the newer examiners becomes one not of my clinical competency or exam performance, but one of the examiners' perception of his responsibilities and his ability to carry out those responsibilities in an unbiased and objective manner. Perhaps if there were a more experienced examiner present during the patient interview segment the hostility and aggressiveness exhibited by either of these two examiners would have been eliminated.

Also, it is questionable how fairly an assessment can be made when both candidate and examiners appear to be

of same approximate age and years of experience.

3. It is my contention that these two examiners allowed their own prejudices and biases to result in hostile behavior and to interfere with their own responsibility to provide an objective assessment of my clinical knowledge, skills and competency. Such behavior only serves to increase the already disproportionate fail rate between U.S. or Canadian medical graduates and that of foreign medical graduates.

Concluding Statements

I firmly believe that I was denied a fair assessment of my clinical skills by the two examiners who treated me in a hostile manner throughout the patient examination. Since I did not know either examiner prior to the exam their inappropriate interactions and attitude toward me leave me questioning whether or not this was due to my status as a foreign medical graduate. Further, the response I received from my request for preliminary review of examination results provided me only with a series of "X" 's representing failing grades. There was no other information to substantiate objective reasoning for failure specific to my actual performance. This lack of specific information not only stimulates many questions in my mind relative to examination objectivity, such as the question posed above, but also place me at a distinct disadvantage in rebuttal of the examiners' assessments, which should be the very crux of this appeal.

I have mentally recalled many times since the examination details of my performance and cannot identify even one deficiency so significant as to warrant a failing

grade in any of the subcategories, which makes failure in five subcategories so absolutely unbelievable. I engaged well with the patient for the full amount of time allowed and, as stated earlier, I conducted the interview in a caring and courteous, but clinically sound, manner. My organization and presentation of data was done in a logical fashion which I, in fact, felt was one of my greatest strengths, gained from many months of practice. The other two subcategories: & Phenomenology, Diagnosis & Prognosis; and Etiologic, Pathogenic & Therapeutic Issues are summarized in the Patient Interview section of this appeal.

I have given honest thought, many hours of time, and careful attention to formulation of this appeal because I am convinced that my preparation and performance resulted in a display of above average clinical skills and competency. I take my professional responsibilities and commitments very seriously and feel deeply insulted and outraged by such disdainful attitudes and the resultant negative effect on my professional goals. As noted on my curriculum vitae, which I am attaching for your review, I am treating a wide range of complex populations such as the dually diagnosed, i.e., mentally ill/chemical abuser, mentally ill/mentally retarded; and children and youth, as well as maintaining a private practice in general psychiatry. Effective treatment of such a diverse patient caseload requires a comprehensive and contemporary knowledge of psychiatry. Additionally, for many years I have been active with the Alliance for the Mentally Ill which has increased my sensitivity that I am committed to maintaining a high level of competency in all aspects of psychiatry.

If one carefully examines the facts in this case which

are that I excelled in my academic endeavors (refer to C.V.), currently manage a very complex psychiatric practice, prepared fully for the Part II examination, passed the videotape segment of the exam but failed all subcategories of the patient interview, one would have to conclude that there was, indeed, a very serious discrepancy in performance outcome which requires a full investigation.

In conclusion, my appeal to the Board is that there be a complete reversal of the failing grades and, thereby, a granting of Board certification. Should this not be granted I would consider agreement to a re-examination of the patient segment only, before impartial examiners, prior to the next Part II examination. If neither is granted, I request a copy of both examiners' notes.

If you have any questions or require further information or clarification of any part of this appeal, please write or telephone me at the address and phone number provided below.

Your careful consideration of this appeal is respectfully requested.

\ss
Marcello A. Maviglia, M.D.

Curriculum Vitae

MARCELLO A. MAVIGLIA, M.D.

Education and Training

1983-1987 **Psychiatric Residency, State Univ. of N.Y.-Buffalo, Dep't of Psychiatry, School of Medicine, Erie County Medical Center, Buffalo, N.Y.**

1974-1981 **Medical Degree, University of Rome-Medical School; Rome, Italy. Graduated *cum laude.***

1974 **High School Diploma, Liceo Calssico, Avezzano, Italy; Degree in Humanistic Sciences. Graduated with top honor.**

Employment:

Current:

***Psychiatrist.* Private Practice, Snyder, N.Y.**

***Consulting Psychiatrist.* Our Lady of Victory Hospital, Lackawanna, N.Y.; Baker Hall Day Treatment, Outpatient, and Residential Programs. P r o v i d e psychiatric services to children and youth.**

***Consulting Psychiatrist.* Salamanca District**

Hospital, Salamanca, N.Y.; Changing Seasons Chemical Dependency Program. Provide psychiatric services to chemically dependent, mentally ill population in an outpatient and in patient facility.

***Consulting Psychiatrist.* United Cerebral Palsy Association of Western New York, Cheektowaga, N.Y. Provide psychiatric services to the profoundly mentally retarded.**

***Consulting Psychiatrist.* Lockview Clinic, Lockport, N.Y. Provide psychiatric services to chemically dependent adults, adolescents, and their families in an outpatient setting.**

Past:

***Psychiatrist I.* New York State Office of Mental Health, Gowanda Psychiatric Center, Community Services, Helmuth, N.Y. (10/87-1/89). Clinic and continuing treatment programs for adults. Duties included psychiatric and physical assessment, medication monitoring, progress notes according to uniform case record standards, participating in treatment team meetings, medical/dental staff meetings, attendance of monthly clinical supervisory meetings and continuing medical education activities, delivery of individual psychotherapy, and home visits. Outside of normal working hours I conducted group informational sessions and in services for clients and their family members.**

<u>Licenses/Certificates</u>

New York State Medical License #
New Mexico Medical License #
Educational Commission for Foreign Medical Graduates Certificate #
Board eligible

Memberships

American Psychiatric Association

Alliance for the Mentally Ill, Erie County Chapter (Buffalo, N.Y.)

OMNI Physicians Association

References

Furnished upon request.

Appendix B

ABPN PART II EXAMINATION APPEAL

January 1992: Marcello A. Maviglia, M.D.

OPENING STATEMENTS

I strongly protest the results of the Part II examination which indicate that I failed four of the five subcategories of the Patient Interview and two of the four subcategories of the Audio-Visual segment. I firmly believe that I performed well above any objective criteria which could be applied to assess competency. In both categories of the examination I was able to develop and present appropriate diagnoses supported by a well articulated and methodical reasoning for such formulation.

This was my second attempt for Board certification. After notification of failure on the first attempt in 1990, in which I failed only the Patient Interview segment, I submitted an appeal which resulted in the Board upholding their initial findings of failure. I felt strongly then, as I do now, that the examination process and findings in my particular case was biased and prejudicial. The examination process, instead of assessing my competency, focused on my status as a foreign medical graduate, with the findings being predictable in that I was failed. My appeal cited specific instances of biased behavior exhibited by the examiners.

Shortly after learning of the appeal results I notified Dr. Lawrence Hartmann, APA President, of my concerns.

He, in turn, brought it before the Task Force to Facilitate Communication Between APA and ABPN. I also notified Ret. Senator Vance Hartke, Director, OMNI Physicians Association for Foreign Medical Graduates, of the prejudicial treatment I received during the 1990 Board examination. Senator Hartke then wrote to Dr. Stephen Scheiber on my behalf protesting discrimination of foreign medical graduates. The letter was allegedly circulated with my appeal. I believe that by voicing my concerns regarding the first examination, which is my constitutional right, the Board has, in retaliation, ensured my complete failure on the second examination.

If I were not secure in my conviction that I am a competent psychiatrist, I would accept a finding of failure. Since competency is not the issue, I feel victimized by a system (Board certification) which has been statistically proven to discriminate based on one's national origin. This discrimination is especially hard for me to accept since I now predominately provide psychiatric services to American Indians. In the realm of psychiatry, neglect of the mental health care needs of this population coupled with the demonstrated prejudice of the ABPN are, and should be, a major source of shame for the psychiatric profession.

With this appeal I will continue my effort to be judged solely on the basis of my competency by reviewing the events of the Part II examination.

PART II EXAMINATION EXPERIENCE

The following case was prepared to illustrate my logical approach to psychiatric care. This is not meant to

report in precise detail the history.

Patient Interview:

Patient is a single, unemployed, white female whose chief complaint is in the context of a long-standing history of "ups and downs." At the time of my evaluation she was involved in OPT seeing a therapist as well as a psychiatrist who was maintaining her on Tegretol. Patient reported that the history of "ups and downs' went back to several years ago and that she went through hospitalization "three times for it." She states that the last hospitalization happened several years ago. She has, also, in between the hospitalizations, been involved in a day a treatment program with some benefits.

The course of the illness since the last hospitalization has been stable. She states that she has derived a great deal of help with the implementation of Tegretol therapy. The symptomatology, besides the episodes of "highs and lows," has been characterized, at least on one occasion, by delusional thinking along with hallucinatory experiences. The above symptomotology consisted in the patient hearing the voice of her brother on the car radio. He, according to patient recollection, at that point, seemed to try and control her mind. During that episode patient complained that she was feeling mainly depressed and she stated that she was treated with an antidepressant (not specified by the patient) and Stelazine. This therapy which was apparently successful was later on discontinued. She also reported having been tried on different types of medications without being specific about the names or dosages. However, she mentioned Lithium among these agents.

Along with the above history, she reported having abused alcohol and marijuana for a limited period of her life. She denied, however, any current use. Presently, she states that although she is mostly on the depressive side and that she has been sleeping too much, she has not noticed the symptoms of highs and lows with the same severity as in the past. She states that there are no particular stressors in her life except her involvement with the Alliance for the mentally Ill which is difficult because of the administrative responsibilities. She claims being compliant with therapy and with the self-administration of medication. She also reports that she's taking Tenormin not being able to define the exact reason for which she's taking such medication.

Personal History. Patient claims having been a good student and having obtained a degree in communication. She claims having worked for different major t.v. networks. She states that she gets along well with people although she reports a rather isolated lifestyle without many friends. Her personal life has been characterized by steady relationships with men. Presently, she lives by herself and she is not sentimentally involved with anyone.

Family History. She claims that her family was dysfunctional and she describes her father as having "serious problems." He was portrayed as a drinker and as somebody who was prone to mood swings. Mother was described as a "victim" who would go along with anything father would do. Her brother was also described in a negative fashion as he did not show any empathy for her problems throughout her illness. She claims that her brother may have an addition problems with drugs. No formal psychiatric diagnosis was made for any of these

family members.

Medical History. She denied any medical problems.

Mental Status Exam. Patient looked like a well-groomed, white female, whose relationship with this doctor was very cordial. She smiled through the course of the interview and became somewhat upset and mildly sarcastic when she described her family life. Her motor behavior became mildly restless at that point, being otherwise normal during the course of the interview. Affect showed a full range of emotions. She became anxious and somewhat angry when describing the family history. Mood seemed to be essentially euthymic and appropriate to the affect. However, patient reported having been depressed lately. Thought content: she reported having been rather overwhelmed with her involvement with the Alliance. Her report about family also showed angry feelings towards the family members, especially father. Thought process: goal directed most of the time, however, somewhat circumstantial at times. Speech, on the line of the thought process seemed to be goal directed most of the time but somewhat circumstantial at others. Neuro-vegatative signs: she states that lately she has been oversleeping. Insight: she admitted having problems and needing treatment although she was not very specific about dosages and types of medications in the past. Overall insight seemed to be fair. Judgement: she saw her future in the context of the illness. She reported plans to continue her education. Her judgement could be classified as fair. She denied any suicidal or homicidal ideations.

Case Formulation. This is a single, unemployed, white

female in her mid-twenties who has a long-standing history of "ups and downs." She reports having been in the hospital three times. She also states that she had been treated with different psychotherapeutic agents, among which she mentions Lithium. She states that presently she is taking Tegretol and Tenormin. She was unspecific as to why she was taking Tenormin. Along with the history of mental illness, she reports a time limited history of drinking and drug abuse. She denies any current history of it at the present. Currently, she describes one stressor which is characterized by her involvement with the Alliance for the Mentally Ill. Her personal history seems to be characterized by a steady pattern of relationships with men. She presently seems to live a rather isolated lifestyle. Family history is positive for substance abuse problems. She claims that her father was a drinker and her brother was involved in drugs. There is no documented psychiatric history in the family. Mental status exam was salient for a cordial relationship with this doctor, a depressed mood, feeling of anger toward family, and some preoccupation about her involvement with the Alliance. There was some circumstantiality in her speech pattern. The neurovegatative symptoms were characterized by some trouble sleeping. The main defense mechanism seemed to be the one of denial or suppression as she hesitated in talking about the extent of her symptomotology and treatment to this doctor.

***Diagnostic Impression*: I. Bipolar Disorder, Depressed Phase, Provisional; R/O Schizoaffective Disorder; R/O Polysubstance Abuse or Addiction; R/O Schizophrenia, Paranoid Type. II. Borderline traits; R/O Borderline Personality Type. III. No Diagnosis. R/O Hypertension (because of the use of Tenormin) IV. Current**

stressor is characterized by her involvement with the Alliance for the Mentally Ill. #2 Enduring stressors are characterized by mental illness, life isolation, relationship with family. V. Level of functioning presently is around 69 because of symptoms of depression. In the past it seemed to have been averaged around mid-70's.

***Treatment*: 1. Review old records in order to corroborate diagnosis of Bipolar Disorder. 2. Since patient is describing a rather depressed mood, plus oversleeping, this doctor would check the Tegretol level. 3. CBC with differential along with Thyroid Profile to rule out side effects of Tegretol as well as thyroid pathology. 4. Patient will be evaluated for current history of drug and alcohol abuse or addiction through referral to an outpatient clinic dealing with these problems. 5. Patient's psychotherapy would be mainly exploring more data to rule out or rule in a diagnosis of Borderline Personality Disorder. 6. Involvement of the family in therapy would be explored. However, according to data furnished by the patient this involvement seems to be rather unlikely to happen because of the emotional distance existing among family members.**

Note: This report is not geared to furnish a detailed history or diagnosis and treatment plan, but rather to show a logical and consequential approach. Regarding establishing rapport with the patient, upon leaving the interview the patient complimented me on my performance.

Discussion:

This doctor found that although the female examiner was appropriate and cordial, she also nodded her

head frequently. This is, indeed, a very misleading factor in the process. I would also like to state that the senior examiner forgot to collect the card at the beginning of the interview, which he was supposed to do. Therefore, the interview was interrupted when the director came to sign the card. He also stopped the interview five minutes before the due time. During the interview he was not very attentive and interested in what this candidate had to say. In fact, at one point, for whatever reason, he dozed off for about twenty seconds. At another point, when this candidate stated that one of the symptoms reminded him of a Schneiderian criteria, that same examiner replied, in a rather sarcastic and obscure way, "Schneiderian criteria, that's it then!"

Additionally, this candidate found it very distressful to be in a commission that was chaired by the ex-chairman of the Department of Psychiatry, Buffalo, N.Y., where I had completed my residency. I feel that this was part of the orchestration which was going on in order to ensure my failure.

***Audio-visual Segment*:**

My impression of this part of the examination is that my organization was definitely appropriate. I gave appropriate rule outs. The examiners were too young in age, which was a problem I cited in my previous appeal. Again, I want to emphasize that I am capable of organizing my thoughts and reaching an appropriate diagnosis and a consequential treatment plan.

SUPPORTING COMMENTS

The Board certification process has been severely criticized many times for its subjectivity in development of competency criteria as well as for its lack of specific and individualized feedback to candidates. Additionally, there is a glaring inconsistency between the rates at which candidates pass the written part of the examination and the rates at which those same candidates pass the oral part of the examination. Bias definitely occurs in the oral part of the examination.

According to an article in the American Journal of Psychiatry (138:3, March 1981), over 95% of 1, 160 psychiatrists responding to a questionnaire regarding their experiences with the ABPN, maintained that detailed feedback on (oral) examination performance should be provided routinely for unsuccessful candidates. However, ten years later candidates are still only provided with a simple series of x's indicating which subcategories were failed, accompanied by a page of general comments. This certainly does not constitute detailed feedback and illustrates a flagrant disregard for candidates' input.

The same article reveals that candidates feel that the Board does not clearly indicate its criteria for competence. This is supported by another article (Resident and Staff Physician, October 1980) which states that the Part II examination is too subjective and dependent upon the whims of the examiner, i.e., the examiners's interests and biases.

The quality of examiners is a major concern to most candidates. In both of my appeals I cited specific instances

of unprofessional conduct on the part of the examiners. *The American Journal of Psychiatry* (148:12, December 1981) reports candidates describing examiners as "having poor attitudes (intimidating, hostile, negative, arrogant, rude, indifferent, etc.), being subjective and biased, having a poor examining technique, having a different orientation, being inattentive, being unable to understand, and being unreasonable. " My own firsthand experience with Board examiners, and reporting of such experiences, along with the opinions of over one thousand colleagues, appears to be of little interest to the Board. Again, ten years have passed since publication of such articles and little has changed.

Finally, even in the most recent issue of *Psychiatric News* (December 20, 1981), an article which addresses recertification emphatically states that the process "will not be a repetition of the initial certification examination, meets the needs of members, as well as develop appropriate educational approaches to prepare members to complete recertification successfully." This statement suggests that the current Board certification process does not meet the needs of its members nor does it adequately prepare candidates for successful examination (or re-examination).

SUMMARY

It is my contention that failure of this examination was a direct result of retaliatory action taken by the ABPN in response to my previous contacts with the APA President as well as the involvement of the OMNI Physicians Association on my behalf.

The outcome of this recent examination was well

orchestrated in that I was failed in the same subcategories within both the Audio-Visual segment and the Patient Interview category. I believe that the almost total failure in both categories was an attempt to discourage me from filing an appeal as well as ensuring that I couldn't make a point, as I did with the last exam results, that by passing one of the categories I was able to prove clinical competency to some degree.

I am asking that there be a complete reversal of the failing grades and that I be granted Board certification. I also request that specific information regarding my actual examination performance be provided to me. I have suffered quite deeply from the fact I am being denied the full status of my profession on the basis of my national origin and the fact that I graduated from a foreign medical school. This process has been allowed to become discriminatory and has victimized many candidates who, like myself, are competent clinicians.

Further, because I am a competent psychiatrist I will pursue all options for remediation of the discrimination I have been subjected to throughout the Board certification process. I have the motivation as well as the financial resources to engage whatever civil and legal activities are necessary to stop this illegal discrimination. It is an outrageous abuse of power that a certifying commission, such as to the ABPN, can blatantly discriminate against candidates based on their national origin; can year after year ignore the serious flaws of its own process and can ignore the constructive feedback which APA members have offered over the past years; cannot prove the objectivity of its own examination criteria; and, finally, is obviously fearful of exposing its

weaknesses by repeatedly refusing to provide candidates with even a minimum amount of specific information regarding their actual examination performance.

\ss
Marcello Maviglia, M.D.

DATE: January 6, 1992

Appendix C

ABPN:PART II EXAMINATION APPEAL

February 1, 1993: Rafael Sanjuan, M.D.

Sent via: Certified Return Receipt #P 234 262 486

Stephen C. Scheiber, M.D.
Executive Vice-President
American Board of Psychiatry and Neurology, Inc.
500 Lake Cook Road, Suite 335
Deerfield, Illinois 60015

Re: Request for Formal Appeal of Part II Board Examination
(Clinical Psychiatry: Patient)

Please be advised, pursuant to the Appeal Procedure effective January, 1992, this letter and supporting documentation (in quadruplicate), hereby serves as notification to the Psychiatry Council for a review of the examinee's Clinical Psychiatry examination taken on November 16, 1992.

Please, find enclosed the following Exhibits to support the examinee's appeal:

•Organization and Presentation of Data	**Exhibit A0-6**
•Discussion of the Diagnosis	**Exhibit B1-2**
•Discussion of the Prognosis	**Exhibit C**
•Discussion of Therapeutic Issues	**Exhibit D**
•Conduct of the interview	**Exhibit E**
•Response to ABPN General Comment	**Exhibit F**

(Letter dated January 4, 1992)

•Comments About Question and Answer Period **Exhibit G1-2**

Based upon the rebuttal information set forth above, the following reasons for a reversal of the negative determination should be considered in addition to the following summaries set forth below on each area of the examination subcategories:

•*Organization and Presentation of Data*: The examinee utilized the allocated time to gather the relevant information and provided the examiners with a focused presentation of the patient.

•*Discussion of the Diagnosis*: Although a minimum of three items are required to make the diagnosis for psychoactive substance dependence as set forth in the Diagnostic and Statistical Manual of mental Disorders (DSM-III-R), the examinee presented eight (8) items to support the diagnosis, as required. Furthermore, the items may be verified by a review and investigation of: the patients medical records, arrest record, employment history, collateral interviews. The diagnostic items are not only unusual but unique to the patient (i.e. The patient's loss of employment because of intoxication at the "cruise liner", "loss of steady girlfriend due to heroin addiction in 1990", Sexual impotence attributed to using "over 40 mg" of methadone, hospitalization for the treatment of hepatitis at "age 19 I Pittsfield, Massachussets", hospitalization for the treatment of accidental overdose at "age 20 in New York." etc.) *See*: Exhibit B 1-2.

•***Discussion of Prognosis.*** **The examinee's prognosis of the patient as fair to good as set forth by the patient's eight (8) unique and unusual positive factors and the two (2) negative factors is evident by the synthesis of the history and mental status examination (i.e. absence of criminal behavior, antisocial traits, absence of suicidal attempts, education beyond high school, etc.)** ***See*****: Exhibit C.**

•***Discussion of Therapeutic Issues:*** **The examinee's suggested treatment plan was a multimodality approach which is the "accepted standard of treatment in the 1990's" for opiod dependence. See: Exhibit D.**

•***Conduct of Interview:*** **The examinee developed an excellent rapport with the patient as evidenced by the abundant, detailed, and relevant information the patient allowed the examinee to collect.** ***See:*** **Exhibits A & B.**

Exhibit A₀

•Identifying data
•Present illness
•Past history
•Psychiatric
•Medical
•Review of systems
•Family History
•Personal and social history
•Mental status examination

•Most likely diagnosis
•Differential diagnosis
•Formulation
•Workup
•Treatment Plan
•Prognosis

Exhibit A1

Organization and Presentation of Data

The patient is an unemployed 39 y/o, single, Protestant, white male, who resides with his mother and is presently in his 20th month of outpatient methadone maintenance treatment.

Present Illness
Upon direct examination, the patient stated that he came in for treatment because he was "addicted to heroin badly, mainlining [The patient refers to the intravenous use of the drug as mainlining], 30 to 40 mg/day". He had lost his job as a waiter on the World Yacht cruise liner because of incidents of erratic behavior due to his heroin intoxication (For example, the patient stated he took over tables assigned to other waiters and served the wrong dishes to customers). The patient made several statements that indicated his desire to end his addiction, as characterized by: "I wish somebody would stop me from buying drugs, I tried to cut down my heroin use", He further stated the "high" would last 3 hours, but then "I would feel that something was missing." He further stated, that he would have feelings of anxiety, nervousness, nausea, and the need

to look for more heroin to get rid of those feelings and to prevent "intermittent chills and hot flashes." The patient further stated that at night, he would experience tremors, irritability, and insomnia.

The patient states that he does not eat much and denied dieting, anorexia, bulimia, the use of laxatives, diuretics or self induced vomiting. The patient offered that he did not have an "eating disorder." He further denied any feelings of depression. In response to my inquiries, he denied experiencing any feelings of depression. In response to my inquiries, he denied experiencing any type of hallucination or delusions. Other than the behavior associated with his obtaining drugs, he denied obsessions or compulsions. He also denied ever trying to hurt himself.

The patient's relapse that culminated in his seeking treatment started at the age of 35. He returned to drinking alcohol by starting with one or two scotches on weekends and increased to 5 scotches per day over a period of 2 years. At the age of 37, he switched from alcohol to heroin, using 5 mg "mainline" on weekends, and a couple of "passes" of cocaine also on weekends. Shortly thereafter, he lost his job as a waiter in a delicatessen. For the next 6 months he was unemployed and used his savings to support the addiction. He then landed a job as a waiter for the world yacht cruise lines, which he lost after 6 months because of the erratic behavior (described above). By then, he had increased the use of cocaine to 1 mg/day "snorted", and heroin to 30 mg/day "mainline". [He denied sharing noddles.] He then entered the methadone maintenance program and is now on 60 mg/day, plus he buys an additional 1 or 2 bags of heroin daily at 6 p.m. because of withdrawal symptoms.

Exhibit A2

PAST HISTORY

PSYCHIATRIC

The patient began using drugs under peer pressure in Junior High School, at the age of 13. Initially, his intake was: amphetamines "black beauties" (2-3 per day), alcohol (6-7 beers nightly). He further experimented on week-ends with heroin 5-10 mg "main ne", by the age of 19, he had increased the use to a daily dosage of 20 mg "mainline." The same year the patient also contracted hepatitis and was treated at Pittsfield, Massachussets General Hospital. The heroin use continued until the age of 20, when he accidentally overdosed on a batch of high quality heroin. He was treated at St. Lukes Hospital for the overdose. The patient stated that, "The overdose, the bout of hepatitis, and being fed up with being high all the time and getting no pleasure from life" caused him to reevaluate his behavior. Subsequently, he stopped using drugs for the next 13 years. During this remission period, he studied music, practices saxophone, flute and piano. While in remission, he also worked in a delicatessen as a waiter.

MEDICAL

There were no major illnesses prior to age 19. In 1971, at the age of 19, the patient contracted hepatitis and was treated in Pittsfield, Massachusetts. In 1972, at the age of 20, patient accidentally overdosed on a batch of high quality heroin and was treated in St. Lukes Hospital in New York.

REVIEW OF SYSTEMS

The patient had a full physical exam approximately 8 months ago. Other than suffering from hemorrhoids, the patient denied having any medical problems, denied any liver, cardiac or pulmonary disease. The patient denied having had any strokes or being infected with AIDS. When asked about bacterial endocarditis, malaria, hepatitis sequelae, he replied that he had no knowledge of being diagnosed as such. The patient denied having medical complications associated with the sue of non-opiod drugs or alcohol. The patient denied, seizures, blackouts, shakes.

He also denied drinking in the morning (He denies drinking presently) He denied having any allergies, and denied taking medications from non-psychiatric M.D.'s.

Exhibit A3

Family History

The relevant family history is that the patient's mother (protestant) is an alcoholic. He described her as "the typical alcoholic with a denial of her problem. She handles stress and physical pain with alcohol (vodka)." The patient's mother worked as an accountant and office manager, she now receives supplemental retirement income, and is neither in treatment nor attending self support groups like A.A. or Rational Recovery." Their relationship was described as "she does her thing-I do mine". He described his Jewish father as a professional billiard player who did not use drugs and did not drink. His father is presently residing in a nursing home afflicted with Alzheimer's disease. The patient stated he gets along well with his only sibling, an older brother. His brother was described as having a "special linking of similar things

happenings to both of them even when they are not in contact with each other." He stated they [he and his brother] experienced certain pains at the same time and instinctively knew when the other was in danger. His brother also uses street drugs. The patient stated, "He [his brother] did all drugs like me. He started skin popping cocaine, and is now mainlining." He started skin popping cocaine, and is now mainlining." The patient added that with it [cocaine], he [his brother] is lost.

Personal and Social

The patient is the youngest of 2 brothers. He does not know if his mother was an alcoholic when she was pregnant, with him, but believes his birth delivery was normal. He does not recall having any separation anxiety and denies being molested as a child. Although he admits to being somewhat shy as a child, he states that he got along well with his neighbors and peers.

Despite the fact that he started using drugs when was 13 Y/O, he graduated high school with a B average, and denied having major problems in school. He further denied any truancy, any episodes of fighting or violence and denied stealing.

He worked as a waiter in a delicatessen for several years, and for six months also as a waiter in the World Yacht cruise lines.

The patient has no military history.

The patient admits to being arrested once, as result of jumping the subway turnstile. However, he denies any other criminal activity. He also denies serving time in jail

or having beer, charged with any other crime.

The patient had a steady girl friend until 1990. According to the patient, his relapse into drugs and decline in sexual function after increasing the intake of methadone to over 40 mg, put an end to the relationship. He has been sexually inactive for the past 6 months.

He presently stays at home and plays piano and saxophone and watches T.V. He visits his father 3 times per week at the nursing home and attends group therapy week days.

Mental Status Examination

The patient is a pleasant 39 y/o single, white male, who is appropriately dressed and looks younger than his stated age. He speaks rapidly and spontaneously with an overabundance of ideas. He describes his mood as normal and denies experiencing any anxiety or depression. His observed affect was moderately euphoric. He denied delusions, hallucinations, obsessions, compulsions, as well as any suicidal or homicidal ideas. His cognitive functioning was essentially intact. He wa oriented to person, place and time.

***Concentration* is good: There is no difficulty whatsoever in "serial sevens."**

***Remote memory* is good, remembers specific years of treatment, name of hospitals and childhood themes with his brother. He recalled President(s) Bush, Reagan, Carter and Ford.**

***Recent past memory* (past few months) is good (he recalled incidents from the previous months at the clinic, jobs, etc.)**

***Recent memory* (past few days) good: Able to recall exactly what day he missed treatment.**

***Immediate retention and recall:* Repeated the six digits**

forward and backward without any mistakes, recalled the three objects after 5 minutes without any difficulty.
The responses to the judgment question about what he would do if he found a stamped addressed envelope in the street, was the socially accepted answers, "to drop it in the mail box." (However, I would have expected him to open the envelope to look for money for drugs).

Most likely diagnosis:
Most like this is a case of Opiod Dependence because of the intoxication with opiods while fulfilling major obligations at work, taking larger amounts and over longer periods of time, marked tolerance, characteristic withdrawal symptoms (feeling anxious, having feelings that something is missing, nervous-nauseous, restless sleep, irritability, unsuccessful efforts to cut down and wishing that somebody would stop him from buying heroin.

I would like to look further into the absence or denial of antisocial features, and depression which are commonly associated with drug dependence; and the effects on the patient of the illness of his parents.

Differential
Primary Anxiety Disorder: **Is the patient medicating himself?**
Primary Mood Disorder: **Is the patient medicating himself?**
***Alcohol Abuse or dependence*:** **Based on the patient's previous alcohol use, the risk associated with having an alcoholic parent, and to rule out present use.**
***Cocaine Abuse or dependence*:** **Based on the patient's previous cocaine use, the patient having a brother heavily addicted to the intravenous use of cocaine, and to rule**

present use.

The examinee emphasized that, "to rule out a primary mood or anxiety disorder it would be helpful to have the patient free of drugs and to observe his mood." The examinee brought up the question, "is the patient medicating himself for feelings of anxiety, depression or other condition?.

Formulation

The patient may have a biologic vulnerability to affective disorders, which in the setting of an alcoholic mother, an addicted older brother, the social conditions of the inner-city slums, as well as the patient's personality traits and emotional states make the drug induce euphoria attractive and his heroin drug dependence a way of life.

Work Up

Review of the patient medical records. Verify further the history of alcohol, cocaine and other drug use. Toxicology to monitor present use, and to "rule in or out" other possible diagnosis. Interview collateral informants.

Prognosis

If the history elicited is accurate, with the proper management the prognosis for this patient is fair to good because of:

Positive Factors:

The absence of criminal behavior (Unusual). The absence of antisocial traits (Unusual). The 13 year remission, during which the patient held full time jobs at a delicatessen and the cruise liner. Skills in the arts (music, piano, flute, saxophone). The absence of depression

(Unusual). Having education beyond high school. The average duration of 9 years for Opiod Dependence.
***Compliance with treatment. (See below)**

Negative Factors

An alcoholic parent. Living in the inner city slums.

***Note: Although the examinee did not consider one missed appointment a negative factor, the examiner appeared to weigh heavily the one missed appointment as a negative factor.**

Exhibit B1

Discussion of the Diagnosis

Please be advised that only three out of nine items are required to fulfill the criteria for psychoactive substance dependence. DSM-III-R, infra. at 167.

****The patient fulfilled eight (8) out of the nine (9) items required as set forth below:***

1) Substance often taking in large amounts or over longer period than the person intended:
The patient increased the intake from 5 mg of heroin on weekends in 1990, to 30 mg per day by 1992. See: Exhibit A1

2) Persistent desire or one or more unsuccessful efforts to cut down or control substance use:
The patient stated "I wish somebody would stop me from buying drugs, I was trying to cut down in the weeks before being fired from the cruise liner." See: Exhibit A1

3) Frequent intoxications or withdrawal symptoms when expected to fulfill major obligations at work:

The patient was fired from 2 jobs [The Delicatessen 1990, and the World Yacht Cruise lines] in 1991 because of intoxication]. See: Exhibit A1

4) Important social, occupational, or recreational activities given up because of substance use:
The patient lost his steady girlfriend in 1990, because of his substance use. The patient is alone and sexually inactive.) See: Exhibit A1

5) Continued substance use despite knowledge or having persistent or recurrent social, psychological, or physical problems that is caused or exacerbated by the use of the substance:
The patient acquired hepatitis when he was 19 Y/O and was treated at Pittsfield, Mass. General Hospital. The patient overdosed on heroin when he was 20 Y/O. The patient's sexual impotence which he attributes to using over 40 mg of methadone. See: Exhibit A2-3.

6) Marked tolerance: need for markedly increased amounts of the substance (i.e. at least 50% increase in order to achieve intoxication or the desired effect, or markedly diminished effect with continued use of the same amount:
The patient increased the intake of heroin, from 5 mg in 1990 to 30 mg by 1992. (600% increase). See: Exhibit A1

7) Characteristic withdrawal symptoms:2
Feelings of anxiety, nervousness, nausea, tremors, insomnia, irritability, intermittent chills and hot flashes, feeling that something is missing, taking more heroin to get rid of those feelings. See: Exhibit A1.

8) Substance often taken to relieve or to avoid withdrawal:
The patient would take more heroin to "get rid of those (withdrawal) feelings. The day of the examination the patient stated, "I get these feelings around 6 P.M., last Friday I went to buy a couple of bags." See: Exhibit A1.

B. Some symptoms have persisted at least one month, or have occurred repeatedly over longer period of time:
The symptoms have persisted for more than 2 years since the patients' relapse, and 7 cumulative years when the patient's heroin use from ages 15 to 20 is included. See Exhibit A1.

Exhibit C

***Discussion of the Prognosis*:**
If the history elicited is accurate, with appropriate management the prognosis for this patient is fair to good because of:

Positive factors:

- **The absence of criminal behavior. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 18.**

- **The absence of antisocial traits. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 18.**

•The 13 year remission, during which the patient held full time jobs. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 18.

•Absence of suicidal attempts. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 16.

•Education beyond high school. *See. Michael A. Jenike, M.D., Ch. 13: Psychiatry, VI Drug Abuse, Scientific American Medicine, Apr. 1991, at 1.*

•The average duration of 9 years for Opioid Dependence. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 18.

•Fairly good compliance with the treatment.

Negative factors.

•Having an alcoholic parent. *See. Michael A. Jenike, M.D., Ch. 13: Psychiatry, VI Drug Abuse, Scientific American Medicine, Apr. 1991, at 1.*

•Having an addicted brother.

•Living in the inner city slums. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 15.

Exhibit D

***Discussion of Therapeutic Issues*:**
The examinee stated that [There was no single beat treatment for the patient], and suggested a multimodality approach with selection or inclusion of:

•Along with the treatment of Opiod Dependence: Antidepressants and/or psychotherapy if depression is present. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 16.

•Alcohol treatment along with A.A. or rational recovery if alcohol proves to be a problem. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 16.

•Therapy, in which responses to:
Environment conditioned responses to feelings and situations originally associated with the drug use (i.e. addict friends, attenuated withdrawal symptoms that may affect the patient in ways he does not recognize, the neighborhood, needles, patient ways of coping with depression and anxiety are death with.) See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 15.

•Al-Anon: This program may help both, the patient and his alcoholic mother.

•Family counseling. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 15.

•Vocational training. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 15.

•Job counseling. See: Lester Grinspoon, M.D. & James B. Bakalar, *Drug Abuse and Dependence, The Harvard Medical School; Mental Health Review* (1990), at 15.

CONDUCT OF INTERVIEW

At the onset of my 30-minute interview of the patient, the examinee made the patient feel comfortable and appreciated. The examinee introduced himself, introduced the two examiners who were present, inquired about how the patient would like to be addressed, and expressed his appreciation to the patient for the cooperation in participating in the examination. The examinee asked the patient what his understanding was about the examination. "The is an examination interview." The examinee also clarified who was being examined. It was also explained to the patient that there was another examiner participating [the floater] and that he would be coming in and out to assist in the examination.

The examinee shook hands with the patient, and made initial observations of his general appearance, facial expressions, and motor coordination.

Although the physical constraints of the examination room and the placement of the patient (closely between one of the examiners and myself without any close access to the exit door) did not present an ideal interview setting, the examinee made every effort to make the patient comfortable. The rapport established was excellent, superseded only by the retrieval of relevant data from a cooperative patient.

During the course of the interview, the examinee looked directly at the patient, dept appropriate eye contact and conducted the interview with empathy and human respect. The patient was allowed to speak freely without any interruptions during the initial minutes of patient "free speech."

Although the patient had a tendency to engage in rambling discourses, the examinee avoided a directionless interview by redirecting the flow of the interview whenever necessary.

The examinee used the full 30 minutes of interview time, and cushioned the end of the interview by asking the patient, "Is there anything that I did not ask that would help me to understand you better?" The patient responded, "No, you covered it all." The examinee then accompanied the patient to the examination room door, and thanked him once again for his cooperation. The patient responded, "This was fun!"

The examinee's attire for the interview wa a navy pin-striped suit, white shirt, conservative, i.e., presenting a well-groomed appearance. The examinee also carried with him a fresh package of facial tissues.

Response to ABPN's General Comments (Letter dated January 4, 1993):

Paragraph 1. **The examinee's history and mental status examination were well organized as evidenced in exhibits A1-6. The examinee utilized the entire 30 minutes allocated for the patient interview. The examinee formed an excellent rapport with the patient and conducted follow up on patient leads during the examination. See: Exhibits A1-6.**

Paragraph 2. **The examinee formulated questions focusing on the clinical materials presented by the patient. The examinee conducted the examination with empathy as evident by the grading of the subcategory: Physician-Patient Relationship. See: Exhibit F2.**

Paragraph 3. **The differential diagnosis/formulation of the case was clearly a focused synthesis of the information derived from the history and mental status examination of the patient. The listing of diagnostic investigation(s) was not conducted in a scattered "shotgun" fashion. See: Exhibit A1-3.**

Paragraph 4. **The examinee arrived at a single diagnosis of Opiod Dependance. See: Exhibit B1-2. The examinee did in fact apply the information collected to the patient's specific clinical situation. See: Exhibits C & D. The examinee volunteered extensive views about the case and provided sufficient information to justify a passing grade to the examiner. See: Exhibit A1-6.**

In conclusion, based on the evidence presented, and the response to the ABPN's General Comment letter of

January 4, 1992, the examinee's negative determination warrants a reversal by the Committee to Review Appeals.

\ss
Rafael Sanjuan, M.D.

Enclosures(s): Exhibits A-G

Appendix D

ABPN'S GRADING SHEET:VIDEOTAPE
Examiner's Name
(Print)_____

Examiner's Signature	Preliminary Grade			Consensus Grade		
	P	C	F	P	C	F

OBSERVATION OF DATA P HC LC F

ORGANIZATION & PRESENTATION OF DATA P HC LC F

SPECIFIC DEFICIENCIES-OTHER COMMENTS

OBSERVATION OF DATA P HC LC F

ABPN'S GRADING SHEET:
LIVE PATIENT INTERVIEW

SPECIFIC DEFICIENCIES-OTHER COMMENTS

ABPN'S GRADING SHEET:LIVE PATIENT INTERVIEW

Examiner's Name
(Print)_____

Examiner's Signature	**Preliminary Grade** P C F	**Consensus Grade** P C F
PHYSICIAN-PATIENT RELATIONSHIP (write legibly)	P HC LC F	
CONDUCT OF INTERVIEW	P HC LC F	
OBSERVATION OF DATA	P HC LC F	
ORGANIZATION & PRESENTATION OF DATA	P HC LC F	
_PHENOMENOLOGY, DIAGNOSIS & PROGNOSIS	P HC LC F	
ETIOLOGIC, PATHOGENIC & THERAPEUTIC ISSUES (write legibly)	P HC LC F	

BIOLOGIC **PSYCHOLOGIC** **SOCIAL**

SPECIFIC DEFICIENCIES-OTHER COMMENTS

Appendix E

American Medical Association
International Medical Graduates
January 1993

In September 1992, the United States Senate and House Representatives completed and President Bush signed landmark legislation that protects international medical graduates, who make up one-fifth of US physicians, against discrimination. There is a clear prohibition of discrimination based on, among other variables, "educational affiliation."

This long-sought legislation also establishes the American Medical Association's National Credential Verification Service as the official repository for IMG credentials. The NCVS was set up to streamline reciprocal licensure and to reduce paperwork. NCVS provides a central source of accurate information throughout an IMG's professional life.

Passage of the Health Professions Education Extension Amendments of 1992, commonly known as the Solarz/Kennedy amendments, is an historic achievement for all IMGs and testifies to the personal efforts of many IMGs and to the strong lobbying efforts of the American Medical Association.

At a glance, this is what the law says:

- residency programs that discriminate based on country of medical training lose certain types of federal education funds.

- a new National Advisory Council on Medical Licensure will recommend ways to make the licensure process nondiscriminatory and establishes the AMA's National Credentials Verification Service as the official system for verifying and maintaining credentials.

- Dept. of Health and Human Services will study licensing in 10 states to determine whether IMGs are treated differently than US graduates.

In the near future, we need to cooperate to assure that the most qualified members are appointed to the mandated National Advisory Council on Medical Licensure. This Council needs informed, broad-based, representative members to carry out its purpose effectively.

The AMA's Advisory Committee on IMGs will hold its fourth annual IMG Forum this year in Washington, DC, March 10-12, 1993. This gathering of IMG organizational representatives has become the policy-setting forum for key IMG issues. Before the opening of the meeting, bonus sessions are available on parliamentary procedure and organizational consensus building. At the meeting, small group discussions will evaluate programs designed to help IMGs and

to establish new directions for future activities. Implementation of the Kennedy/Solarz amendments, next legislative steps, AMA/NCVS, developing unity for effective positive action, and ways to increase IMG representation in organized medicine are the leading discussion topics. Ethnic organizations, state, county and national specialty society IMG sections and committees - plan to send your representatives! Need more information? Write directly to: Jack Hotaling, Director, IMG Services Unit, AMA, 515 N. State St., Chicago, IL 60610.

The AMA Advisory Committee on IMGs has just adopted an advocacy program for IMGs who experience difficulties with licensing or in finding employment. When written details of alleged discrimination are received, the Advisory Committee chair assigns it to a committee member for review. A recommendation is then made for appropriate kinds of involvement, including any advocacy actions that are warranted. This program has been highly effective in redressing these wrongs.

Appendix F

From the President
Psychiatric News/September 18, 1992

APA and IMG's

We all recognize that the field of psychiatry - and medicine in general - is facing difficult times right now. To strengthen our field as well as work toward improving the quality of and access to care, we need to pull together; we cannot afford to allow the field to splinter into self-interested factions or disenfranchise any of our members.

One important membership group that APA has tried to incorporate into its governing structure is the international medical graduates (IMG's). One of my goals as president this year is to tap into this group even more, particularly as my strategic planning process for APA gets underway.

Dr. Munoz has been extraordinarily active on the Board of Trustees in representing the needs and interests of IMG psychiatrists. In this column, he reflects on the numerous accomplishments and contributions of IMG's to the Association and identified areas where APA needs to improve IMG representation.

Dr. Munoz is a private practitioner and clinical professor of psychiatry at the University of California at San Diego.

\ss\
Joseph English, M.D.

APA President

By Rodrigo Munoz, M.D.
APA Trustee at Large

Dr. Leon M. Lederman of the Enroco Fermi Institute, chair of the Board of Directors of the American Association for the Advancement of Science, said in his recent presidential lecture: "Increasingly, research will be transnational, as huge facilities will be shared and the national origin of companies becomes less interesting. An increasing number of nations will enter the research and development community. Here, we can include Korea, Singapore, eastern Europe, and the former Soviet Union, as well as Brazil, Mexico, Argentina, and other developing nations now enjoying democratic reform but suffering from transitional economic problems. Competition for who will have the best educated, best equipped, most acceptable sites for new commercial activities will increase. Let's not forget that, while we are intent on becoming number one by the year 2000, the present number ones are not standing still, waiting to be overtaken."

Dr. Lederman's call for the cessation of parochialism in science has been better than answered in the American Psychiatric Association. Its 8,000 international psychiatrists will let no one doubt that there is more knowledge about world psychiatry in APA than in any other place, including the World Psychiatric Association.

International medical graduates (IMG's) are proud, hard-working group, which is today represented among leaders in many areas of psychiatric endeavor, including mental hospital administrators, chais of psychiatric departments, administrators of medical organizations, productive and influential researchers, and distinguished clinicians. From senior advisors at NIMH, to editors of national psychiatric journals, to leading investigators at research institutes, many IMG's continue to make many contributions to American psychiatry.

IMG's also are devoted to the care of the poor, the chronically ill, and the homeless in the state hospitals (wherever they still exist), federal and municipal hospitals, mental health centers, the poorer areas of the big cities, and rural America.

Research has indicated that those IMG's who make it to become fellows of APA are as successful professionally as their U.S. graduate colleagues. There are several factors that account for this.

Almost any successful IMG has in his or her early history the selfless and laborious effort of teachers, researchers, and supporters in the United States who guided him or her to success. In my own case, within one month of having arrived in the United States, I had support and guidance provided by

Dan Freedman in his research laboratory. Later, for five years, I benefited from many hours of personal contact with Eli Robins, George Winokur, and Sam Guze in clinical work, teaching, and research. Their efforts created my professional life in psychiatry.

The checkered life of IMG's as a professional group has often taken a turn for the better because of the individual and courageous action of a psychiatric leader. In the many years I have been active in APA, I have seen the effects of vigorous decisions in support of IMG's made by all recent APA presidents, including thinkers and leaders like John Talbott, Dan Freedman, George Tarjan, Carol Nadelson, Bob Pasnau, Paul Fink, Larry Hartmann, Joe English, and many others. The six years Jack McIntyre was chair of the APA Membership Committee intitiated the fastest advance of IMG's in the APA fellowship process. This progress has continued through the efforts of Mike Vergare, Donna Harris, and Aaron Wolf. In his short period as a leader of the Assembly, Dick Bridburg has already galvanized it to help the ImG's.

I do not write this article to say that all is well with the IMG's. The money that APA loses in one year because IMG's are leaving the organization would go a long way toward paying for a full-time IMG on APA's staff who would serve the 22 percent of members that are IMG's.

Almost 30 years in American psychiatry have given me the impression that the study of the IMG's is like the study of the two sides of the moon. Let's talk about the dark side. As bright as the bright side is, the dark side is pretty dark.

The IMG's expect that an increasingly dynamic interaction between the APA Board of Trustees and the Office

of the Medical Director will decrease any self-defeating division between insiders and outsiders in APA. To the extent that any IMG's may have felt alienated from APA by a perceived lack of sensitivity on the part of any member of the APA staff, I am committed to do all I can to improve the relationships between IMG's and staff, if any problems are found to exist.

IMG's are heavily represented among psychiatrists in public programs and in facilities that care for the poor. The current crunch in public mental health funding has affected many IMG's. IMG's have been affected by economic issues so severely and for so long that we are among those who have been thinking about solutions for the longest time. WE could be much better represented on the APA Council on Economic Affairs.

The situation in the private sector is not much better than in the public sector. Discrimination under current health programs against providers of care for the mentally ill has been especially severe against IMG's. We are flatly denied access to patients in many managed care programs. This discrimination may not end until the current non-system is replaced by a national program in which all American shave the same access to health care. Courageous and open debate on this master within APA components that deal with managed care and universal access to health care.

Education has been a major concern for most IMG's from the time we were residents. Many have chosen to devote their endeavors exclusively to training centers. Many other have made sure that they stay involved in academic activities. We want to have an effective voice on the APA Council on Medical Education.

IMG's are among the most enthusiastic supporters of international education as a way to validate the leadership of American psychiatry in the world. We want to be part of this effort and are willing to do our best to make it successful. For this, we count on personal and professional contacts in most countries on all continents. We should be members of any APA component dealing with international education.

We have not had adequate access to the APA periodicals so that our efforts on behalf of psychiatry and on behalf of the IMG's who are working within APA are called "Uncle Tom" or "Tio Taco" or other colorful names, I think I can understand the frustration of those who use them. We need to convince those involved in decision making that as long as the ImG's do not know that somebody cares about them, they may leave the organization. The APA publications, especially *Psychiatric News*, should offer coverage to the IMG's in the same proportion as to everybody else. Making up for lost time, there could be a story on the successful struggles IMG's have had in the recent past. f This may permit those who are disclined to say in APA to learn that our organization has not been oblivious to their concerns. IMG's should be represented on the editorial board of *Psychiatric News* to continue the work of its longtime chairperson, Dr. George Tarjan, an IMG, who died this past year.

Almost 10 years ago, the American Journal of Psychiatry published information demonstrating that the IMG's were vastly underrepresented among the ABPN directors, consultants, and examiners. Many IMG's believe that a plantation mentality exists in the ABPN that does not permit the directors to ever consider an IMG as a legitimate candidate for director. After many years of looking into the situation, often with the help of very distinguished APA leaders, I

myself do not have any answers.

Those who believe that because I have been on APA committees that select candidates for ABPN directors for several years; because I have been a member, and then chair, of the Task Force on Communications between APA and the ABPN; and because I have the attention of the APA Board of Trustees, I should have the tools to help the IMG's with the ABPN, simply are not aware of the complex relationships within APA and the ABPN. As long as the ABPN is a separate corporation run by directors who are not sensitive to the IMG's and their concerns, the situation is likely to remain the same..l AS has been the case for years, I am very willing to hear any opinions on this matter.f

An indication that we are not alone in our feelings about eh ABPN may be the recent history of ABPN directors who have been candidates for APA office: virtually all of them have ben defeated.

I want to thank the APA president for opening this column to me and the to the IMG's. His concern for all APA members and their patients is obvious and gives me great hope. We all expect drastic changes in APA in the years to come. As new structures evolve and new ways of thinking emerge, the IMG's may be more important than ever to APA. When Joe English is talking about erasing the frontiers between public and private psychiatry and devoting our efforts to the best psychiatry for all, we want all IMG's back in APA, joining dour colleagues in search for the best solutions for problems we share. For those who are disillusioned or tired, I should say that new opportunities are here again and we need a strong APA, now more than ever.

Appendix G

Commentary

INTERNATIONAL MEDICAL GRADUATES FACE LICENSE AND CERTIFICATION PROBLEMS
by Rodrigo A. Munoz, M.D.

Foreign medical graduates want to be called international medical graduates (IMGs) because this designation is more realistic; IMGs are seldom "foreign" to this country. There is no "typical" IMG, but if we use statistics to establish a profile, the average IMG is of non-Hispanic European ancestry, was born in the United States, and has a successful clinical practice. IMGs represent more than 33 percent of psychiatrists in five populous states and about 25 percent of those practicing throughout the country.

Three issues affecting IMGs in psychiatry include: APA fellowship, licensure, and board certification.

APA Fellowship

Several studies have shown that fellowship in the APA separates the IMGs into two groups. The first is comprised of those who have become fellows and are professionally successful as U.S. graduates. They are usually board certified, have university appointments, and are active in organized medicine.

The second group consists of those who are fellowship-eligible. The IMGs in this group differ from U.S. graduates in that they see more patients per week, see more patients with schizophrenia, and work more often in community mental health centers and hospitals not connected with medical schools. In other words, IMGs who are not fellows tend to be busy in areas that many consider less desirable.

In the early 1980s, aware of the results of the fellowship surveys, IMGs made a major effort to increase the number of those who met the criteria for APA fellowship. This effort has been successful; in the last six years the proportion of IMGs achieving APA fellowship has been equal to that of U.S. graduates.

Licensure Problems

As long as there is no uniform national policy regarding licensure by medical boards, IMGs will continue to confront hurdles that occasionally are ridiculous. A few years ago, a state medical board asked ImGs to fill out a 40-page questionnaire. It even asked the salary of the founder of the medical school the IMG attended. We wondered how those graduates from old European universities could obtain this information and, even it they could, whether it was an appropriate question.

The Health Professionals Reauthorization Act passed by Congress on September 20, 1988, included a measure calling for a survey of state licensing policies to see if any discrimination exists

against licensed IMGs who seek licenses by endorsement in other states. The Government Accounting office (GAO) must determine if there is any discrimination and, if so, in which states, IMGs are anticipating the survey results will show discrimination.

The report by the GAO, "Medical Licensing by Endorsement: Requirements Differ for Graduates of Foreign and U.S. Medical Schools" does not answer all the issues raised by those who requested study. Sen. Paul Simon (D-I11.) recently introduced bill S251 to prohibit discrimination against foreign medical graduates in licensure, residency, and privileges; and to establish a National Record Repository. The bill, which would amend the 1986 Health Care Quality Improvement Act, died in committee last session, but a spokesman for Simon said the senator plans to reintroduce it this year.

Board Certification

Poor representation of IMGs among American Board of Psychiatry and Neurology (ABPN) examiners, consultants, and directors has been a problem. The APA has met with the ABPN, presenting a strong case for increased IMG participation. This line of communication has been promote by the Task Force on Communications between the APA and the ABPN, the Council on Education, and the Board of Trustees. ABPN directors appear to be motivated to increase IMG participation.

The proportion of lifetime board certified IMGs is quite low. This problem requires immediate attention, because ABPN

certifications obtained after 1994 will have to be renewed every 10 years.

A recent survey conducted by the Task Force on Recertification indicated that most uncertified psychiatrists would welcome an opportunity to become certified. Since the ABPN claims not to be interested in training those who are not fully prepared for the ABPN examination or who fail it repeatedly, the challenge now lies with the APA; helping its members obtain a permanent board certification before 1994 will not only be beneficial to members but also to the psychiatric profession. (At press time, the APA Board of Trustees voted to develop strategies to increase the number of IMGs as board-certified psychiatrists.)

Effective training courses and non-graded examinations, such as the PRITE, could be useful in promoting certification among IMGs and deserve additional attention.

I would like to encourage readers of *The Psychiatric Times* to think about training courses and mock examinations that may be useful in order to promote certification among our colleagues.

Dr. Munoz is clinical professor of psychiatry at the University of California, San Diego.

Appendix H

PSYCHIATRIST IN THE U.S. AS OF 6/23/93

TOTAL Number of Psychiatrists:
31,046

U.S. Med. School Grad:
22,098 (71%)

International Medical Grad:
8,948 (29%)

TOTAL Number Board Certified:
19,055 (61%)

U.S. Med School Grad:
15,107 (79%)

International Medical Grad:
3,948 (21%)

TOTAL Number Non-Board Cert:
11,991 (39%)

U.S. Med. School Grad:
6,991 (58%)

International Medical Grad:
5,000 (42%)

Of the total number of U.S. Medical School Graduates (22,098),
68% are Board Certified.

Of the total number of Internationl Medical School Graduates
(8,948), 44% are Board Certified.

Appendix I

FROM:OMNI PHYSICIANS ASSOCIATION FOREIGN MEDICAL GRADUATES

TO:DOCTOR MAVIGLIA

March 26, 1991

Dear Doctor Maviglia:

Your situation is extremely unfortunate. It is another example of the discrimination that is being practiced against Foreign Medical Graduates are being mistreated because they are not Graduate of U.S. Medical College.

We will pursue your case with Dr. Stephen C. Scheiber, the Executive Board Chairman of the American Board of Psychiatry and Neurology, Inc.

Your case is one in which the organization providing the testing is controlled by anti-Foreign Medical Graduates. They are protecting the U.S. Graduate by denying equality of treatment to Foreign Medical Graduates.

Your record is indicative of your high qualifications. The patient interview segment of the examination are subjective in nature and difficult to attack. You are right in demanding specific explanation of the board's rating. The "form letter is not an explanation. It is an excuse for an explanation.

We will bring your case to the attention of the Congress. In addition you should write to your Senators and Congressmen and ask them to help OMNI pass anti-discrimination legislation.

Please keep us advised as to your situation.

Sincerely,

ss/

Vance Hartke
U.S. Senator, Ret.

Appendix J

FROM: OMNI PHYSICIANS ASSOCIATION
FOREIGN MEDICAL GRADUATES

TO: DR. MARCELLO MAVIGLIA

March 26, 1991

Stephen C. Scheiber, M.D.
Executive Vice President
American Board of Psychiatry and
Neurology, Inc.
500 Lake Cook Field
Suite 335
Deerfield, Illinois 60015

Re: Dr. Marcello Maviglia

Dear Dr. Scheiber:

We have been requested by Dr. Marcello Maviglia to intervene in his case concerning his alleged failing of Part II of the examination. He has filed an appeal after receiving your form letter notice of rejection.

It is unfortunate that the Psychiatric Board has taken the position of failing to substantiate the finding of the board examination.

Dr. Marcello Maviglia has never been even a marginal performer. He has always had an outstanding record and graduated Cum Laude from the University of rome Medical School. He passed the videotape part of

the examination which demonstrates that the oral examination should have a corresponding result-instead of the completely contradictory grade he was given in Part II. Since it did not, the hostile and snide attitude of the examiners is a factor that becomes significant.

The fact that Doctor Maviglia is a Foreign Medical Graduate raises a much significant problem in view of the already current opinion that the board is discriminating against Foreign Medical Graduates.

This issue of discrimination against Foreign Medical Graduates is currently before the United States Congress. the issue was the subject of a May, 1990 General Accounting Office report in regard to licensure by endorsement.

One of the items presented to the general Accounting Office was the sharp and consistent drop in the number of Foreign Medical Graduates approved by your Board.

It is our sincere desire to be able to see equality of treatment for all physicians without prejudice and discrimination. If it cannot be performed under the present self regulating system, then regulation by legislative action in the U.S. Congress will be necessary.

Your comments and suggestions will be expected.

Sincerely,
ss\Vance Hart, U.S.
Senator, Ret.

Appendix K

FROM: MEDICAL SOCIETY OF THE STATE OF NEW YORK

TO: VENKATACHALA PATHY, MD., CHAIRPERSON AND RANDALL D. BLOOMFIELD, MD., CHAIRPERSON

October 19, 1992

Dear Colleague:

The Medical Society of the State of New York (MSSNY) is trying to assist international medical graduates -- not just with words, policy statements and position papers, but in very tangible ways.

To help support these efforts, and to protect our IMG activities from organization-wide budget cuts that are being made due to the current recession, we have established an IMG Activities Fund.

This is to ask your help in supporting our fund.

You can do so either through a direct contribution or through membership. As a special incentive to encourage IMGs to join, MSSNY has agreed to direct up to 50% of your first year's dues payments to the IMG Activities Fund, if you join before the end of 1992.

This way you can reap all the benefits of membership and still direct a meaningful contribution to IMG activities.

The IMG Activities Fund will be used to support projects developed by our Subcommittee on International Medical Graduates; projects like the following:

MSSNY's Annual Educational Forum for IMGs Seeking Residency Positions
Each year, MSSNY brings together representatives of the Educational Commission for Foreign Medical Graduates, the National Resident Matching Program, the New York State Education and Health Departments and United States Visa Services to help guide candidates through the process for obtaining a residency.

The program also features opportunities for candidates to meet residency program directors from hospitals throughout the state and obtain information on and file applications for their programs.

These are just two projects which ar presently being discussed. Our committee meets throughout the year and the list of activities we might undertake with added funding is a long one.

Of course we will remain active in opposing discrimination against IMGs -- whether by licensing boards, the federal or state government, residency programs or even medical societies.

But we do need your help. Even mailing a letter to IMGs throughout the New York

state costs thousands of dollars and puts quite a strain on our budget. We hope that you will join MSSNY to support our activities and the other activities of the Society that are so crucial to the future of all physicians today. Act now and you can ensure that up to 50% of your MSSNY dues payment is directed to the IMG Activities Fund.

If for some reason you cannot join at this time, please contribute whatever you can to our efforts. We'll see to it that all contributions are recognized in an appropriate manner.

A postage paid envelope is enclosed for your convenience in responding. Please make membership checks payable to the appropriate county medical society; contributions should be made payable to "MSSNY IMG FUND."

We thank you very much.

Sincerely yours,

ss/

Venkatachala Pathy, MD, Chairperson
Membership Subcommittee on International Medical Graduates

ss/

Randall D. Bloomfield, MD, Chairperson
Membership Committee

P.S. If you join now, your dues payment will be credited for 1993 and you will receive **free** membership for the remainder of 1992.

Contributions or gifts to the MSSNY are not deductible as charitable contributions for federal income tax purposes. However, dues payments are deductible by most members as an ordinary and necessary business expense.

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Appendix M

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Journal of the American Medical Association

JAMA 1992; 267: 783-784

February 12, 1992

SECTION: MEDICAL NEWS & PERSPECTIVES

LENGTH: 1378 words

TITLE: Harassment Linked to Fraud, Lawsuit Alleges

AUTHOR: by Paul Cotton

TEXT:
ALLEGATIONS that sexual harassment at the National Institutes of Health (NIH), Bethesda, Md, led to research fraud are now part of a federal lawsuit under the Racketeer Influenced Corrupt Organizations Act.

If false, the charges are a heinous insult to highly reputable researchers. If true, they constitute perhaps the most egregious example of what some women's health advocates say is the extent to which

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sexual harassment can be damaging not only to the women in medicine but to the science of medicine itself. (See preceding article.)

Maureen Polsby, MD, says it all started when she refused to go to bed with the man who recruited her for a medical staff fellowship at the (then) National Institutes of Neurologic and Communicative Disorders and Stroke (NINCDS), which since has been reorganized into the National Institute of Neurological Disorders and Stroke and the National Institute on Deafness and Other Communicative Disorders.

Thomas Chase, MD, who was clinical director and is now laboratory chief, says that "as a matter of policy" he does not comment on anything undergoing investigation. However, in court depositions he has denied all charges. Another author on the allegedly fraudulent paper calls the charges "preposterous and absurd."

Tests Challenged

Polsby says Chase gave her research ideas to male colleagues. She says that they then published papers in peer-reviewed journals based on her work. Certain tests were reported as being done that Polsby and at least one subject in the study say were

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not done.

A suit charging both sexual discrimination and fraud was dismissed by a US District Court judge in Maryland December because Polsby had not filed her complaint within the existing 30-day statute of limitations (since raised to 90 days) on sex discrimination complaints by federal employees. She has now filed a new suit containing only the racketeering-provision allegations.

Calls for an investigation of the case outside of court apparently have not resulted in action to date. Sen Thomas A. Daschell (D, SD) requested the congressional General Accounting Office to investigate. An aide to the [page ended]

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Appendix N

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The Boston Globe

January 27, 1993, Wednesday, City Edition

SECTION: METRO/REGION; Pg. 15

LENGTH: 728 words

HEADLINE: Sex harassment charges probed; Tufts medical school targets professor

BYLINE: By Alison Bass, Globe Staff

KEYWORD: SEX BEHAVIOR PROBE NAME-SHADER NAME-NEW ENGLAND MEDICAL CENTER NAME-TUFTS UNIVERSITY SCHOOL OF MEDICINE

BODY:
Tufts University School of Medicine and New England Medical Center, Tufts' teaching hospital, are investigating allegations that Dr. Richard I. Shader sexually harassed a number of women who worked or trained under him in the late 1980s, officials at both institutions said yesterday.

The medical school has set up a fact-finding committee to study the allegations against Shader, the chairman of the Tufts Department of Psychopharmacology, and the medical center has instructed its

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professional standards committee to look into the matter, the officials said.

Meanwhile yesterday, the former executive director of the American Board of Psychiatry and Neurology, a national panel that certifies psychiatrists, said a number of women who worked on his staff had complained to him that Shader made unwanted sexual overtures to them in the early and mid-1980s. Shader was serving as a member of the board at the time, and most of these overtures allegedly occurred while Shader and the female employees were traveling around the country administering tests for board certification, said Dr. Lester Rudy.

"He didn't do any forcing, but they felt like he was pushing himself on them," Rudy, who is now retired as executive director of the board, said in a telephone interview. "One very young lady - she couldn't have been more than 19 or 20 at the time - complained that he had banged on her hotel room in the early hours of the morning and demanded to come in. She was very upset."

Shader could not be reached for comment yesterday. He has previously said he never engaged in any sexual harassment.

The state Board of Registration in Medicine last month put Shader on what amounts to probation and restricted his psychiatric practice after he admitted to having sexual relations with a female patient in the mid-1970s. The board warned that this judgment

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would be set aside and the case reopened if there were other charges of sexual misconduct against Shader, a psychiatrist who continues to teach, do research and see patients for diagnostic evaluations.

Last year, Tufts medical school awarded Shader tenure and a department Chairmanship while the state regulatory board was investigating the female patient's complaint and after New England Medical Center settled for $ 90,000 a separate sexual harassment complaint against Shader by a hospital employee in 1991 in a Globe article published last week, several Tufts faculty members said they were disturbed that Tufts medical school officials had granted Shader tenure, despite knowing about both the $90,000 settlement and the state board investigation.

The woman who filed the harassment complaint with New England Medical Center's human resources department gave up her job as a condition of the settlement and has been unable to find another one in the same field, according to sources familiar with the case. The woman alleged that the harassment took place on many occasions over a number of years and consisted of Shader's fondling her, pulling her against him, kissing her on the mouth when he could catch her off guard and repeatedly scratching himself in the crotch in her presence, according to these sources.

Another Tufts faculty member, who asked not

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to be identified, also said she had been sexually harassed by Shader in the late 1980s, while she was a trainee at the university. She described a pattern of harassment similar to the one sources described in the New England Medical Center complaint.

Walter Cabot, chairman of New England Medical Center's Board of Governors, said yesterday that the hospital's professional standards committee had been instructed to review all the allegations against Shader and take "appropriate action." Cabot said the hospital should always take harassment complaints seriously and investigate them fully.

"If a hospital doesn't do these kind of things, it's negligent," Cabot said. "This kind of activity and any effort to cover up this kind of activity does not benefit any institution in the long run."

Although Cabot said he did not know how long the hospital's review of allegations would take, the fact-finding committee set up by Dr. Morton Madoff, dean of the Tufts medical school, has been instructed to get back to Madoff with the results of its investigation within a month, said Rosemarie Van Camp, a medical school spokeswoman.

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Appendix O

National Library of Medicine MEDLINE Database

TITL: Audit of oral examinations in psychiatry.

AUTH: Allison R; Katona C

ORGA: Department of Psychiatry, University College and Middlesex' School of Medicine.

CITE: Med Teach 1992; 14 (4): 383-9

LANG: ENG; English

ABST: This study describes a simple set of statistical parameters for assessing the reliability and validity of oral examinations (OE). Traditional feedback to examiners tends to categorize them as 'hawks' or 'doves' on the basis of whether their personal mean mark is above or below the group mean. Our study shows that the mean OE mark on its own is not a good measure of examiner performance. We suggest that inter-rater reliability between examiner pairs is e more satisfactory indicator of reliability and face validity. The correlation between the OE marks given by an examiner and the student's subtotal from written parts of the exam (SUBTOT) is suggested as a useful

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indicator of OE validity. These measures, as applied to our own student exam results, suggest that our OE examiners are performing at an acceptable standard of agreement (Cohen's Kappa for pass/fail 0.74, $p < 0.0001$), and support the use of the OE as a method of student assessment.

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Appendix P

Letters to the Editor - Am J Psychiatry 133:6, June 1976

On the Boards Again

SIR: I agree with the recommendations and conclusions in "Experiences of Psychiatry Board Exam Casualties: A Survey" by Martin R. Lipp, M.D. (March 1976 issue).

Years ago, I talked with a number of candidates who passed the Boards and some who failed one or another portion. Those who failed were bitter, railing against the very poor quality of the choices of possible answers to the questions and also against the often obvious and occasionally vindictive biases or prejudices of the examiners.

One man was brilliant in his ability to memorize books of reference, etc. During the orals, his sole task was to find out the "school" of the examiner and then to slant his exposition. He passed easily, but as a clinician he was a nothing.

When I worked for the Department of Mental Hygiene some time ago, I took a promotional examination. At that time, my orientation within the field of psychiatry was changing to a more physical and nutrients-disturbance etiologic approach. I suddenly found myself in empathic disarray with the examiners and realized my progressive disaffection with the field of psychiatry and my increasing discomfiture as a traditional psychiatrist. That was a devastating period for me. I eventually left state employ for private practice.

The psychiatric literature and I are increasingly at odds, to the point that I experience "psychiatry" as an alien intrusion. Given this, I could imagine the scenes should I attempt the Boards, which, in my opinion, do not reflect the individual's knowledge, skills or comfort in working within the field of psychiatry. They reflect the expectations of a group of like-minded persons, the need for conformity, and the societal strength that comes from such conformity in addition to the biases and prejudices of the examiners and individuals who make up the questions.

The Boards should reflect capacity for work, thinking ability and range, creativity within working relationships, individual integrity and openness - the marks of an expert within his chosen field - without regard to someone else's preconception. I would consider standing for such a display of my thinking and working. Until then, I consider the Boards an onerous and unfair device for image projection to society, a restrictive device within the psychiatric profession, and an ego display to oneself.

GEORGE P. CONGRAM, M.D.
Dix Hills, N.Y.

Appendix Q

LEXIS: National Library of Medicine
MEDLINE Database

TITL: From board candidate to rookie examiner.

AUTH: Napoliello MJ

CITE: Am J Psychiatry 1977 Nov; 134 (11): 1264-6

ABST: The author describes his experience as a candidate for the American Board of Psychiatry and Neurology, Inc., examinations one year and as an oral examiner the next. He discusses the oral examination process, listing the errors most frequently made by candidates.

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Appendix R

LEXIS: National Library of Medicine MEDLINE Database

National Library of Medicine MEDLINE Database

TITL: The Canadian certification examination in psychiatry. III. Towards better certification techniques.

AUTH: Lowy FH; Prosen H

CITE: Can Psychiatr Assoc J 1979 Jun; 24 (4): 292-301

ABST: Although there has been much criticism of specialty certification examinations there is general agreement that they are an important safeguard of competence in medical specialties where the consumer cannot judge this. The Canadian Royal College has made strenuous attempts to improve certification techniques but these have not been heretofore widely reported. This paper reports on the rationale for the replacement of the essay examination by multiple choice questionnaires, the problems associated with MCQ, and the efforts made to improve the fairness, validity and reliability of the clinical (oral) examination. These

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efforts have been in the areas of selection of examiners, training for examiners, standardization of marking and the conduct of the examination. A description is given of the conduct of the examination and what the examiners look for in the candidate's performance. The development and increasing importance of the In-Training Evaluation are discussed. The publication of A Resident's Guide to Psychiatric Education with multinational participation advances the possibility of future reciprocity in psychiatric examinations conducted in several English speaking countries.

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Appendix S

National Library of Medicine MEDLINE Database

TITL: Sex and the boards.

AUTH: Jacobs MH; Flowers LK

CITE: Am J Psychiatry 1980 Oct; 137 (10): 1226-8

ABST: In 1978 a questionnaire on the functioning of the American Board of Psychiatry and Neurology was mailed to a sample of APA members. The authors present the significant differences in responses between men and women psychiatrists. A higher percentage of women than men were among thoes who had experienced stress from the time and effort involved in taking the Board examinations and from fear of the oral examination; 45% of the women respondents who had received certification had done so since 1975 versus 23% for the men. The authors discuss possible explanations for the sex differences, including role strain, and suggest greater flexibility in where, when, and how Board examinations can be taken.

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Appendix T

National Library of Medicine MEDLINE Database

TITL: The Oral Board Examination: a call for its demise.

AUTH: Gardos G

CITE: J Clin Psychiatry 1980 Dec; 41 (12 Pt 1): 422-4

ABST: The author's personal experiences as a candidate as well as relevant publications have led to the conclusion that the Oral American Board of Psychiatry and Neurology (ABPN) examination does not serve the best interest of the profession. The Oral is invalid, unreliable, painful and unnecessary. Residency Training Programs are responsible for the imparting of basic clinical skills, while psychiatric knowledge and competence may be adequately tested by written exams supplemented wih audio-visual techniques. (AUTHOR)

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Appendix U

National Library of Medicine MEDLINE Database

TITL: Examination success and opinions on American Board of Psychiatry and Neurology certification.

AUTH: Quick SK; Robinowitz CB

CITE: Am J Psychiatry 1981 Mar; 138 (3): 340-4

ABST: Psychiatrists who completed residency between 1967 and 1978 completed questionnaires about their experiences with the American Board of Psychiatry and Neurology (ABPN). Although the 1,160 respondents were basically positive about the ABPN, performance on the Board examinations was strongly related to their degree of satisfaction with the examination process. The opinions of psychiatrists who had not sought certification mirrored those of respondents who had failed the exams. The oral examination was uniformly seen as stressful, but respondents also wanted the Board to provide more clear criteria for the judgment of competence as well as detailed feedback on performance. Women and

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foreign medical graduates were less apt to be certified than male psychiatrists who had graduated from United States medical schools, and psychiatrists engaged in research, education, and/or administration tended to be more successful at passing the Board examination than were clinicians.

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Appendix V

National Library of Medicine MEDLINE Database

TITL: A practice oral examination rating scale -- inter-observer reliability.

AUTH: McCormick WO

MNTR: Can J Psychiatry 1981 Jun; 26 (4): 236-39

ABST: Three videotaped practice clinical, oral examinations were rated by 9, 9 and 11 raters respectively. Raters were all certified specialists engaged in training residents for the certification examinations. In two of the simulated examinations considerable differences in rating scores, to the extent of pass/fail disagreement, were found. The significance of the findings, including the possibility that one examiner may "contaminate" another, is discussed. Further work is essential to develop reliable instruments for rating certification examinations, whatever their format, as the Royal College policies evolve.

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Appendix W

National Library of Medicine MEDLINE Database

TITL: Reasons given for success after initial failure on the American Board of Psychiatry and Neurology Part II Examination.

AUTH: Rudy LH; Kulieke MJ

CITE: Am J Psychiatry 1981 Dec; 138 (12): 1612-5

ABST: In an attempt to help understand the Part II oral examinations of the American Board of Psychiatry and Neurology, the authors undertook a study to identify the factors that aid candidates in passing the Part II examination after one or more initial failures. A total of 339 diplomates rated 13 reasons hypothesized for passing Part II. The major factors that influenced passing on subsequent attempts were 1) the experience of having taken the examination previously (81%), 2) different examiners (66%), 3) decreased anxiety (61%), 4) additional studying (59%). Other factors suggested by diplomates for passing after initial failures included less fatigue and fewer personal problems.

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Appendix X

National Library of Medicine MEDLINE Database

TITL: A study of the reliability of the clinical oral examination in psychiatry.

AUTH: Leichner P; Sisler GC; Harper D

CITE: Can J Psychiatry 1984 Aug; 29 (5): 394-7

ABST: A study of the variability between raters in scoring an oral clinical examination in psychiatry in the format of the certification by the Royal College of Physicians and Surgeons of Canada is reported. A video-taped examination from another centre was rated independently by academic psychiatrists, nonacademic psychiatrists and residents. Considerable inter-rater differences between and within these groups were found. In particular, the averaging of the marks of pairs of raters as occurs in the actual certification resulted in the outcome depending to a considerable degree on the chance pairings of raters. These findings support a number of previous studies and emphasize the need to train examiners and to develop clearer rating criteria. (

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Appendix Y

National Library of Medicine MEDLINE Database

TITL: Reliability of the Part II Board Certification Examination in Psychiatry: interexaminer consistency.

AUTM: McDermott JF Jr; Tanguay PE; Scheiber SC; Juul D; Shore JH; Tucker GJ; McCurdy L; Terr LC

ORGA: Department of Psychiatry, University of Hawaii at Manoa, Honolulu 96826.

CITE: Am J Psychiatry 1991 Dec; 148 (12): 1672-4

ABST: OBJECTIVE: The aim of the study was to examine the reliability (interexaminer consistency) of the American Board of Psychiatry and Neurology (ABPN) Part II (oral) examination in psychiatry. METHOD: Grades were assigned independently by two examiners who observed the same examination in a 1-year cycle (1,422 candidates, two examinations each). The consistency between these pairs of grades (pass, condition, fail) was analyzed using a weighted kappa statistic. RESULTS: There was perfect agreement between examiners in 67% of examinations, minor disagreement in

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26%, and major disagreement in 7% (weighted kappa = 0.54-0.56). CONCLUSIONS: The Part II ABPN examination demonstrates fair to good reliability as measured by interexaminer consistency. Development of more explicit grading criteria should further improve examiner agreement in future examinations.

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Appendix Y

United States District Court
Northern District of Illinois, E.D.

Raphael Sanjuan, M.D. and Marcello A. Maviglia, M.D., PETITIONERS	:
-v.-	:
The American Board of Psychiatry and Neurology, Inc. and Stephen C. Scheiber, M.D., RESPONDENTS	:

93 C 5806

TO: HON. CHIEF JUDGE MORAN

PLAINTIFF'S MEMORANDUM OF LAW
IN OPPOSITION TO
DEFENDANTS' MOTION TO DISMISS PURSUANT TO
F. RULE 12(b)(6)

The Plaintiffs, Rafael Sanjuan, M.D. and Marcello A. Maviglia, M.D., respectfully, by and through their attorney, Patricia L. Johnson, Esq., hereby submit their memorandum of law in opposition to the Defendants' Federal Rule of Civil Procedure 12(b)(6) motion to dismiss for failure to state a claim upon which relief can be granted as follows:

A. Plaintiffs' Have Stated Claim(s) Upon Which Relief Can Be Granted

1. First, although Illinois law prohibits courts in this state from reviewing the admissions or certification processes of private entities, unless such admission or certification is an "economic necessity", the American Board of Psychiatry and Neurology is not a private entity.

2. Second, the Plaintiffs' complaint includes averments of claims made in numbered paragraphs, the contents of each of which are limited as practicable to a statement of a single set of circumstances. Furthermore each claim founded upon a separate transaction or occurrence is stated in a separate count whenever a separation facilitates the clear presentation of the matter.

3. Third, Plaintiffs executed an agreement a part of their application process which is invalid and unenforceable.

Consequently, Plaintiffs respectfully request that the Court deny Defendants' request to dismiss Plaintiffs' complaint, and that this action go forward, without prejudice.

Factual Background

The American Board of Psychiatry and Neurology, Inc. (ABPN) professes to be a non-profit corporation whose mission and purposes is supposed to be to identify qualified medical specialist in psychiatry. However, the ABPN has instead failed to meet its mission and has had no purpose outside of qualifying candidates who meets their standards, namely medical school graduates who are not international medical graduates (IMG's) (formerly foreign medical graduates.

The court must consider the special nature or the corporate activity of the ABPN and the special structure of activities in accomplishing its goals of certifying physicians nationwide in psychiatry and neurology.

Board certification of psychiatrists has become a prerequisite to practicing psychiatrists and continues to be the topic of discussion by leading psychiatric periodicals, namely *Psychiatric News, Psychiatric Times* and others periodicals. Furthermore, board certification is publicized by leading "board certifying courses" as a major requirement for psychiatrists.

COUNTER-ARGUMENT

A. The Applicable State Law Does Not Apply To Plaintiffs' Action Because The ABPN Is Not A Private, Voluntary Association

1. Although the ABPN hold itself out as a non-profit corporation, its certification process for physicians to become specialists in Psychiatry and Neurology allows the corporation to derive substantial revenues from interstate commerce.

2. The non-commercial character of the ABPN and the nature of the service it renders makes it ore of a commercial corporation than a non-profit corporation.

3. Furthermore, when the ABPN approves board certification, it permits this approval to be advertised and engages in a continual promotion of the purpose for the purpose for which it was organized, namely to inform the public that a physician is board certified.

B. The ABPN Derives Substantial Revenues From

Candidates and Monopolizes the Market of Psychiatry Candidates

4. The ABPN, who holds itself out as a non-profit corporation accepts an initial Six Hundred and Twenty-Five ($625.00) Dollars from candidates for the Part I Written examination. Afterwards, granted the applicant passes the written examination on the first try, the candidate is then charged Seven Hundred Dollar ($700.00) fee for the Part II oral examination. In likely event of failure due to the applicant's status as an international medical graduate (IMG), the ABPN then will charge the applicant an additional One Hundred ($100.00) Dollars for a putative "checklist" that serves no purpose but to reiterate a candidate's oral examination negative determination, and then again, as a non-profit corporation requests yet another Seven Hundred ($700.00) fee for a putative "formal appeal."

5. The ABPN is a quasi-public institution empowered with control over the psychiatric certification process. Therefore, the ABPN and its officers are "state actors" and their conduct is state action since if affects physicians seeking board certification in psychiatry.

6. Although the ABPN alleges to be a private institution, it continues to reap the benefits of a public institution and has filed corporate certification as recent as July 9, 1987, as a "not-for-profit" corporation under the Internal Revenue Code. According to the Code, "in determining whether a corporation is commercial, it must look to its nature and not its purpose and through its activities that customarily are carried on for profit are certainly commercial, the activity need not be motivated by profit to be commercial. I.R.C. §1605.

7. The ABPN alleges to qualify under Section 501(c) of the Internal Revenue Code and alleges not to be a branch or agency of any federal, state or local government body. However, many of its board of directors are in fact, members of a government body, and further the ABPN collects at least One Million Fifty Thousand ($1,050,000.00) Dollars in each of the four regions in which it administers exams.

C. The ABPN is a State Actor and Not a Private Association

8. The ABPN and its officers are in fact state actors and their conduct of certifying physicians specializing in Psychiatry is state action based on:

a) The ABPN collects fees in each of the United States.

b) The ABPN administers examinations with the full permission of each states' governing body.

c) The ABPN acts as an arm of the state in that it requires candidates to hold a requisite state medical license. Candidates are required to take and pass the Federation Licensing Examination (FLEX) based on state requirements. The purpose of FLEX is to provide a high-quality, objective and standardized examination for use by physician licensing boards as their own qualifying assessment for license. Such an examination provide a uniform and equitable assessment in terms of content, levels of difficulty, and scoring practices, crating a rational basis for interstate endorsements/reciprocity.

D. Plaintiffs' Are Not Prohibited From Bringing This Action.

9. In the Illinois case of *Treister v. American Academy of Orthopaedic Surgeons*, 396 N.E. 1225 (Ill. Ct. App. 1979),

leave to appeal denied, 79 Ill. 2d 630 (1980), the Illinois Appellate Court held that membership in the Academy was possible based on a showing of "economic necessity." However, the Plaintiffs in the instant case state the ABPN as an umbrella of the state does not fall under the label of a "private association" as espoused in *Treister*. Id.

10. Furthermore, the Defendants' incorrectly referred to *Kaneria v. Am. Bd. of Psychiatry and Neurology, Inc.*, No. 92 D 3543, 1993 Westlaw 413134 (N.D. Ill. Oct. 5, 1993), when they claim that the Kaneria case is an action virtually to this one. See Defs. Mem. Mot. Dismiss ¶ 19. On the contrary, in Kaneria, the Plaintiff alleged breach of contract, negligence and breach of fiduciary against the ABPN only.

11. However, in the case at bar, in addition to suing the ABPN, the Plaintiffs are suing its executive director and successors. Furthermore, the Plaintiffs in the case at bar have sued for over eleven (11) counts, none of which include breach of contract and/or breach of fiduciary duty.

D. The Plaintiffs Claims are Not Putative But Real Claims

12. The Plaintiffs were and continue to be injured by the Defendants wrongdoing and do have standing to maintain a claim against the ABPN. Valley Forge College v. Amer. United for the Separation of Church and State, 454 U.S. 464 (1982).

13. The Plaintiffs injury can be traced to the challenged action, in that, the Board discriminated against the Plaintiffs.

14. The Plaintiffs are not asking the Court for judicial review of the ABPN's certification process but for the Court

to challenge the entire certification process and antitrust violations,

15. The ABPN has used its certification powers to inflate the certification process or psychiatrists who are becoming board certified and have recovered as much as Four Million (4) millions.

16. The group of psychiatrists dictates the lives of IMG's by suppressing their professional growth and depleting their financial projects.

17. The ABPN is rife with conflicts of interest and illegal procedures.

18. The executive director, Stephen C. Scheiber, M.D. has been known to lead a group or examiners and commission directors who have conspired to increase the salaries and professional growth of very few, if any IMG's, restricted the IMG's traveling and worth ethic; forced IMG's to be employed in less than the average salary pay; restricted IMG's and conspired with examiners as well as "board certifying programs to fail IMG's that have excelled academically and professionally, otherwise.

19. To the contrary, most if not all, of the IMG's in the United States, have had a negative impact on their first amendment right to travel; been financially burdensome and restricted their competency to the world concerning their area of expertise.

20. The ABPN has been responsible for certifying psychiatrists, a task delegated by the American Psychiatry Association.

21. The standards for approval of board certification have changed drastically over the pat few years to reflect changes which include: a) outright, covert and overt, discrimination of IMG's by the ABPN examiners and commission directors at the Part II oral examination; b) total disregard for IMG's and their professional background and/or level of expertise prior to their application for board certification; catastrophic application fee increases bordering on illegal assessment by the ABPN of fees that resemble a penalty more than an application fee; c) outright discrimination by haphazardly implementing lifetime certification to all psychiatrists who have passes both parts of the examination prior to 1994 whose number, does not include many IMG's. In fact, the number of IMG's who are board certified are less than 25 percent of the total number of IMG's.

E. The Plaintiffs Have in Fact Pled a Cause of Action for Fraud.

22. Pursuant to Federal Rules of Civil Procedure 9(b), the Plaintiffs averment of the Defendants fraud has been made with particularity. See Compl. ¶¶47-71, 78-89, 92-105.

23. In fact, a cursory reading of the Plaintiffs' Complaint will establish that the Plaintiffs have met the pleading requirements set forth in the local law and Federal Rule of Civil Procedure 9(b).

24. In addition, the Plaintiffs have not filed am action against the Defendants based on promissory fraud but, in fact, made averments based on fraud based on false representation of present conduct. See Compl. ¶¶47-71, 78-89,92-105.

F. The Plaintiffs Have Plead a Cause of Action for Defamation.

25. The elements of defamation are: the defamatory language of the ABPN in that it stated the Plaintiffs' failed its board certification examination; of and concerning both of the Plaintiffs; publication by the Defendants to third persons and entities that included publicizing mailing lists of failing candidates; and damage to the Plaintiffs' reputation as a result of that publication. Since the matter involves that of a matter of public concern, the Plaintiffs are ready to present to this Court, the falsity of the defamatory language of the Defendants; and prove fault on the part of the Defendants.

G. The Plaintiffs Have Plead a Cause Of ActiOn Under the Due Process and Equal Protection Clause of the United States Constitution

26. The Fifth Amendment to the Federal Constitution provides in pertinent part: "No person shall...be deprived of life, liberty or property, without due process of law." U.S. CONST. amend V.

27. Subsection one of the Fourteenth Amendment to the Federal Constitution provides in pertinent part: "No state shall...deprive any person of life, liberty, or property without due process of law." U.S. CONST. amend XIV, §1.

28. The federal courts have pretermitted the issue whether the practice of medicine is "property" under the Fifth Amendment. They have, however, declared that a state cannot exclude a person...from any...occupation in a manner or for reason contravening the due process or equal protection clauses of the Fourteenth Amendment.

29. Procedural due process in connection with the denial of a license to practice...medicine requires that the applicant be given notice and an opportunity to be heard by the body which

rules on the application. The ABPN did not provide the Plaintiffs' with notice and a hearing and the ABPN exercises judicial powers without leave to appeal its decision.

30. Due process requires states to employ fair procedures in processing applications for the various professions and, therefore, that an applicant who has failed the requisite professional examination is entitled to procedural due process.

31. The ABPN failed to adequately provide the Plaintiffs with adequate notice and/or a fair hearing, and instead, has retrieved over Three Thousand ($3,000.00) Dollars per examination collectively from the Plaintiffs.

32. The ABPN has cause the general public, as well as institutions to favor board certified psychiatrists and discriminated against non-board certified psychiatrists.

33. Whether due process is satisfied by the ABPN must depend upon the quality and nature of the activities or the ABPN in relation to the fair and orderly administration of the laws of the United States Constitution for which is the purpose of due process to insure.

H. The ABPN Has Failed To Treat All Candidates for Board Certification Alike and Has Therefore Violated The United States Constitution

34. Pursuant to federal statute, "a person is entitled to a right of action when injured by a conspiracy which deprived the person or class of persons of the equal protection of the

law or of equal privileges and immunities under the laws." 42 U.S.C. §1985.

35. In order to state a cause of action under Section 1985, four elements are required which the Plaintiffs have already asserted, namely:

a) A conspiracy by the ABPN;

b) For the purpose of depriving, either directly or indirectly, any person or class of persons the equal protection of the laws, or of equal privileges and immunities under the laws, as the ABPN has deprived IMG's from obtaining board certification;

c) That the ABPN haphazardly failed the Plaintiffs' in their Part II oral examination in furtherance of the conspiracy and furthermore, implemented a lifetime certification to all those who have received their board certification prior to 1994; and

d) That the Plaintiffs were either "injured in their person or property" and were deprived of having and exercising any right or privilege of a citizen of the United States.

36. Furthermore, the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution requires only that the Court determine whether the clarification bears a rational relationship to a permissible governmental purpose in the ABPN's failure to treat persons "similarly situated alike." U.S. CONST. amend XIV.

37. The actions by the ABPN of certifying psychiatrist nationwide bears a rational relationship to the permissible governmental purpose of deeming psychiatrist well-qualified to serve the general public.

38. The ABPN's actions in grading the Part II oral examination in Psychiatry has limited the liberty of candidates and therefore violated equal protection requirements of the Federal Constitution.

I. The ABPN Has Invidiously Discriminated Against Applicants for Board Certification

39. A prima facie case of discriminatory treatment is established by showing:

a) That the Plaintiffs are both international medical graduates, a racial minority group amongst the majority of psychiatrists;

b) That the Plaintiffs took the ABPN's board certifying examination and in no way failed the examination since both candidates are quite proficient and experts in their particular field of expertise.

c) That despite the Plaintiffs' qualifications, the Defendants failed both Plaintiffs on the Part II oral examination, and

d) That after notification to the ABPN of their erroneous grading of the Part II oral examination, the ABPN failed to adequately review the Plaintiffs' examinations and sustained their allegedly failing grades without meeting the burden of proving the Plaintiffs' failure by a preponderance of the evidence.

40. The ABPN has a history of discriminating against minority candidates and awarding a "blanket" failure on their Part II oral examination which is not subject to review.

41. Out of the total number of IMG's in the United States, only 21 percent is board certified.

42. Both plaintiffs answered questions and provided

answered that can be corroborated as correct in the medical "bible" known as DSM-III. However, no Plaintiffs to date have been given an opportunity to challenge the Defendants due to procedural loopholes in the federal court system.

43. The Part H oral examination, is again, in contrast to the ABPN's written examination different in scope and concept from the written examination. The Part II oral examination is subjective and by the nature of it can be grade more subjectively and inconsistently since the ABPN grades are purportedly written on small index cards and "never" released to the candidate.

J. The Release Agreement Executed By The Plaintiffs As Part Of Their Application Is Unconscionable, Therefore It is Invalid and

Unenforceable

44. When the Plaintiffs originally flied their applications for board certification with the ABPN, in 1982 and 1989, respectively, they were not aware of the inequities within the ABPN's Part II oral examination administration.

45. Furthermore, a cursory reading of the purported "release agreement" will immediately reveal to a legal professional, namely, a one-sided agreement that undoubtedly has assisted the Defendant is avoiding claims for illegal conduct as a part of their examination process.

46. In addition, hold harmless agreements are rarely

executed during an examination process unless the examiner has reason to believe that a claim may be brought against the examiner by the examinee.

47. Although this blanket form recital states that the Plaintiffs have "read and understood" the terms should not prevent the court from holding that there is no contract if the average non-attorney would not understand the provisions to mean for the most part: "that no matter what we as examiners do to you, legally or illegally, you will hold us harmless."

48. Although the Defendants are medical professionals, they are not in fact, proficient in legal terminology or they would not have signed any type of agreement, and more than likely would have retained the assistance of legal counsel in executing the application release agreement if they were apprised of the illegal activities of the Defendants.

49. The Defendants, in fact, finally recognize the Plaintiffs as "highly educated and sophisticated professionals" but chose to instead fail them on a subjective Part II oral examination due to the location of their medical school.

50. Furthermore, in contract law, duties may be discharged by a release and/or covenant not to sue. However, the release must be in writing and supported by new consideration and/or promissory estoppel elements.

51. In the case at bar, although the release was in writing, it was not supported by new consideration and/or promissory estoppel. In fact, the release was executed unbeknownst to the Plaintiffs that they would encounter extreme and unreasonable expenses that were not anticipated, making the release also impractical.

52. Furthermore, the release was executed with the Plaintiffs thinking during a reasonable period of time and under reasonable circumstances that they would be administered the Part II oral examination. However, they did not foresee the discriminatory treatment by the Defendants which completely or at a minimum almost completely destroyed the purpose of the contract; and the purpose of the release was not in fact understood by the Plaintiffs, thereby frustrating the purpose of the release as well.

Conclusion

Based on the real and concrete causes of action asserted by the Plaintiffs and the severity of those actions, as well as all of the foregoing reasons, the Plaintiffs respectfully request that the Court deny the Defendants motion to dismiss their Complaint, and allow this action to go forward, without prejudice.

Dated: December 3, 1993

\SS\
Patricia L. Johnson, Esq.
Attorney for the Plaintiffs

Appendix Z

United States District Court
Northern District of Illinois, Easter Div.

- x

RAPHAEL SANJUAN, M.D. and
MARCELLO A. MAVIGLIA,M.D.,
PLAINTIFFS

-v.-

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC. AND
STEVEN C. SCHEIBER, M.D.
DEFENDANTS

- x

File No. 93 C 5806

TO: HON. CHIEF JUDGE MORAN

PLAINTIFFS' MOTION FOR LEAVE INSTANTER TO FILE A SUPPLEMENTAL MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

Plaintiffs hereby move for leave instanter to file a supplemental Memorandum of Law in Opposition to Defendants' Motion to Dismiss Plaintiffs' complaint, and this action pursuant to Rule 12(b)(6).

INTRODUCTION

Plaintiffs have not embraced a "shotgun" approach in the execution of their complaint. Instead, the Plaintiffs have

asserted a multitude of allegations, stated concrete claims, and have met the standing and jurisdiction requirements. The Plaintiffs have clearly set forth detailed facts that entitled them to relief.

On December 3, 1993, this Court granted Defendants' Motion for Leave to file a memorandum of law that contained twenty-three (23) pages in support of their Motion to Dismiss Plaintiffs' complaint and this action, pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. To date, the Defendants have been successful in avoiding suit and have been allowed to strategically avoid defending serious allegations made against them, both personally and severally. *See Patel v. American Bd. of Psychiatry and Neurology, Inc.*, 875 F.2d 1312 (7th Cir. 1992); *Kaneria v. American Bd. of Psychiatry and Neurology, Inc.*, 832 F. Supp. 1226 (N.D. Ill 1993), respectively.

Further, in the case at bar, the Defendants have made several attempts to bar this complaint from going beyond the pre-trial stage. For example, on November 29, 1993, Plaintiffs counsel duly served defense counsel with Plaintiffs' First Set of Interrogatories in compliance with General Rule 9(g). However, defense counsel chose to file a Motion to Stay Discovery alleging that Plaintiffs' counsel submitted Interrogatories in violation of General Rule 9(g) Although this matter was discussed and rectified in open court on December 3, 1993, Defendants will continue to utilize any tactic to avoid suit.

Plaintiffs are both graduates of foreign medical schools who have been the subject of arbitrary and capricious conduct in the grading scheme of the Part II oral examination, as well as the victims of serious violations of the federal constitution and state laws.

However, irrespective of the defense counsel's pre-trial strategies to avoid suit, the issue remains that serious violations of federal statutes, as well as the federal constitution are being employed by the Defendants. It is apparent that there exists material issues of fact that International Medical Graduates ("IMGs") (formerly known as Foreign Medical Graduates) that have been treated unfairly and have been barred from obtaining board certification in psychiatry by the defendants. See Exhibits. A(1), A(2) and A(3)-American Medical Ass'n, Int'l Medical Graduates (Jan. 1993); From The [APA's] President, R. Munoz, M.D., *Psychiatric News*, Sept. 18, 1992, at 3; Rodrigo A. Munoz, M.D., *Int'l Medical Graduates Face License and Certification Problems*, The Psychiatric Times-Medicine & Behavior (Feb. 1991); Additionally, discrimination by the ABPN has had a substantial impact on IMGs as there are approximately five-thousand (5,000) IMGs in the United States who have not been permitted to pass the Part II oral examination administered by the Defendants. (See Ex. B(1), B(2)-*Statistical Analyses of Passage Rate of IMGs: 1989 ABPN Report; June 23, 1993*) According to a letter written to Marcello A. Maviglia, M.D., by retired U.S. Senator Hartke, "Your case [Maviglia's] is one in which the organization providing the

testing is controlled by anti-Foreign Medical Graduates. They are protecting the U.S. Graduate by denying equality of treatment to Foreign Medical Graduates. (See Ex. C(1)-(3), Letter from OMNI Physicians Assoc. to Dr. Maviglia of 3/26/91; Letter from OMNI Physicians Assoc. to ABPN of 3/26/91; Letter from Medical Society of the State of N.Y. of 10/19/92.) The means employed to arbitrarily and capriciously fail the Plaintiffs have also been criticized in leading psychiatric journals as "invalid, unreliable, painful and unnecessary." (See Exhibits D(1)-(3)- George Gardos, M.D., *The Oral Board Examination: A Call for Its Demise*, 41 J. Clinical Psychiatry 12 (Dec. 1980.); *ABPN's Patient Interview Said to Be an Invalid Test*, Clinical Psychiatry News (May 1990); S. Kaneria, *Letter to the Editor*, Psychiatric Times (March 1993).

To add further to the serious allegations expressed in the Complaint filed in this action on September 22, 1993, it appears there has been no forum that will assist the Plaintiffs in litigating this matter. For example, in 1991, Marcello Maviglia, M.D. wrote to the American Psychiatric Association ("APA") requesting assistance with the flagrant administration of the ABPN's Part II oral examination ("examination.") (See Exhibit E(I) Letter from Dr. Maviglia to the APA of 7/9/91) However, the APA responded by referring the Plaintiff to a purported Task Force to Facilitate Communication Between the A.P.A. and the ABPN. (See Exhibit E(2)-Letter from APA to Dr. Maviglia of 8/13/91) Unbeknownst to the Plaintiffs was the fact that the Task

Force's Chair, Richard I. Shader, M.D., "was charged with making "unwanted sexual overtures [to female ABPN examiners] in the early and mid-80's. Shader was serving as a member of the board at the ABPN at the time, and most of these overtures allegedly occurred while Shader and the female employees were traveling around the country administering tests for board certification." (See Exhibit E(3)-Alison Bass, *Sex Harassment Charges probed: Tufts Medical School Targets Professor*, The Boston Globe, Jan. 27, 1993, at 15.)

Although Congress has acknowledged the sharp and consistent drop in the number of Foreign Medical Graduates, legislation has not stopped the serious violations made with respect to the testing of psychiatric IMG board candidates. Several state medical societies have made attempts to address the flagrant issue of discrimination, but thus far have not prevailed in changing the administration of the examinations to IMGs.

COUNTER-ARGUMENT
PLAINTIFFS' ACTION IS NOT BARRED UNDER ILLINOIS STATE LAW

Pursuant to the United States Supreme Court and the 7th Circuit Court in *Klaxon Co. v. Stentor Elec Mfg. Co.*, 313 U.S. 487 (1941) and *Jaurequi v. John Deere Co.*, 986 F. 2d 170 (1993), respectively, absent a legitimate dispute about the applicable law, the substantive law of the state [of Illinois] should be applied.

In the case at bar, the Plaintiffs contend that the Defendants failed to train

examiners to properly grade the ABPN's Part II Oral Examination ("Examination"); failed to treat all candidates for board certification equally, engaged in a common plan to limit board certification of International Medical Graduates ("IMG's"); violated federal statutory authority; as a result of their discriminatory acts and monopolization of IMG'S, the ABPN has unduly burdened interstate commerce resulting in a not insubstantial effect on interstate commerce; made misrepresentations to the Plaintiffs thereby inducing them to act to their detriment by taking the Part II oral examination; held out the Plaintiffs' names as failing board certification candidates to the public; providing the Plaintiffs with an indemnification agreement that is unconscionable and invalid. See Compl. ¶¶ 21-45,48,50-56,59-71,75-105.

PLAINTIFFS SEEK CERTIFICATION FROM A "MEDICAL BOARD"
THE ABPN IS NOT AN ASSOCIATION

Contrary to the Defendant's analysis of *Treister v. American Academy of Orthopaedic Surgeons*, 78 Ill. App. 3d 746, 396 N.E. 2d 1225 (1979), the Appellate Court of Illinois, First District, Third Division was a decision whereby the plaintiff, Treister who was a duly board certified physician, sought member in an association but was subsequently rejected based on adverse information in his curriculum vitae. Id. at 748, 749. Subsequent to an investigation, Dr. Treister further claimed he was not given a fair opportunity to present his case or rebut the charges against him. Id. at

749. In the case at bar, the Plaintiffs are duly licensed physicians who are highly qualified for board certification in Psychiatric. Unlike *Treister*, the Plaintiffs have not been duly certified but seek board certification. Unlike *Treister*, the Plaintiffs seek board certification and not membership in an association. Unlike *Treister*, the Plaintiffs do not have any adverse information in their personnel/curriculum vitae files that would bar them from board certification. Furthermore, unlike the federal case at bar, the *Treister* case was brought in a state jurisdictional court and not a federal district court. *Id.* at 746. Therefore, the court's ruling in *Treister* does not apply to the case at bar.

However, the Plaintiffs in the case at bar are contending the ABPN has monolistic power over the board certification process of all psychiatrists nationally and internationally. Therefore, Plaintiffs contend that judicial intervention is, in fact, in order since the Defendants' monolistic powers are in violation of Section 4 of the Clayton Act. *See National Ass'n. of Sporting Goods Wholesalers, Inc. v. FT.L. Marketing Corp.*, 779 F.2d 1281 (7th Cir. 1985) (Under Illinois law, judicial intervention was not appropriate since member failed to show monopolistic power.)

Furthermore, unlike *Treister*, the Plaintiffs are not filing suit against an "association." According to *Black's Law Dictionary*, the term "association" is defined as, "an unincorporated society." 156 (4th ed. 1968.); Irving Shapiro, *The New*

Dictionary of Legal Terms 16 (1984). Instead, the Plaintiffs are filing suit against a "board", defined as, "an official or representative body, organized to perform a trust of to execute official or representative function or having the management of a public office or department exercising administrative or governmental functions. Id. at 219. *See State Ins. Fund v. Dinowitz*, 39 N.Y.S. 34, 38 (1950). *See also, Jordt v. California State Bd. of Educ.*, 35 Cal. App. 2d 591, 96 P.2d 809, 811 (1939) (a board exercising certain powers with respect to licensing osteopathic physicians and surgeons.)

Finally, in *Treister*, a case of first impression, the Presiding Judge dissented from the court's decision based on the following rationale:

a) A restrictive application of the 1961 New Jersey Supreme Court case, *Falcone v. Middlesex County Medical Society*, 34 N.J. 582, 170 A.2d 791(1961). (judicial review allowed where local hospitals required physicians to be member of the society, and subsequent refusal by society had serious adverse economic and professional effects.); *Blende v. Maricopa Couny Medical Society*, 96 Ariz. 240, 393 P.2d 926 (1964).

b) Application in prestigious medical society distinguished from social, religious or fraternal organization. *Treister*, 396 N.E. 2d at 1234. *See Pacific Coast Society of Orthodontists*, 1 Cal.3d 160, 81 Cal. Rptr. 623, 460 P.2d 495 (1969); *Falcone*, 34 N.J. 582, 170 A.2D 791 (1961). (Plaintiff's membership application to society could not be denied arbitrarily if

denial would deprive the Plaintiff of hospital staff privileges.)

c) Failure of the majority opinion to acknowledge the public interest;

d) No reviewing court applies Falcone so strictly as in *Treister*;

e) Misapplication of Illinois law of "economic necessity" as espoused in *Van Deaele v. Vinci*, 51 Ill.2d 389, 282 N.E. 2d 728 (1972) (strong economic interest after improper administrative proceeding gives court power and duty to act to protect public welfare and reasonably safeguard livelihood while not impairing the proper standards and objective of the organization.) *Treister*, P.J., dissenting, 396 N.E. 2d at 1235.

Plaintiffs have filed a Complaint, complete with claims upon which relief can be granted. The Complaint contains legally cognizable claims of relief.

In addition to the complaint filed, Plaintiffs' Response in Opposition to Defendants' Motion to Dismiss filed with this Court, on December 3, 1993, contains an array of factual and legally cognizable claims of relief for which Plaintiffs should be allowed to pursue. Even if the Complaint were lacking in substance, which it clearly is not, the United States Supreme Court has upheld for over three (3) decades, "A complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the Plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957.) The Court in *Conley* further states that Federal Rule 12(b)(6) should be read in conjunction with Federal Rule 8(a), which only requires a

"short and plain statement of the claim." Thus, giving the Defendant fair notice of what the Plaintiffs claim is and the ground upon which it rests." Id. at 47-48. (*See* Compl. ¶¶ 21-45: Facts as to Liability; ¶¶46-71-105-Rafael Sanjuan M.D.'s claims; ¶¶72-105-Marcello Maviglia, M.D.'s claims; ¶106-116-Theories of the Plaintiffs' Recovery.

THE ABPN IS A QUASI-STATE BODY AND ACTS AS A AGENT OF THE STATE IN THE ADMINISTRATION OF THE PSYCHIATRY BOARD EXAMINATION

The ABPN is a quasi-public institution empowered with control over the psychiatric certification process throughout the United States. The ABPN and its officers, namely Stephen C. Scheiber, M.D., executive vice-president of the ABPN, are both "state actors" and their conduct may be considered "state action since it affects physicians seeking board certification in psychiatry. Although the ABPN has alleged to be a private institution and has filed for corporate certification as a "not-for-profit" corporation.

Furthermore, the ABPN participates in "state activity" since it requires "board applicants" to take and pass the national statewide Federation Licensing Examination (FLEX). The FLEX is a standard national examination for medical licensure in every state jurisdiction in the United States of America. Unlike the ABPN's examinations, the FLEX is a high-quality, objective and standardized examination for use by physician licensing boards as a qualifying

assessment for licensure. Unlike the ABPN's examinations' the FLEX provides a uniform and equitable assessment in terms of content, levels of difficulty, and scoring practices, which create a rational basis for interstate endorsements and reciprocity.

Although the ABPN's examinations are interstate, they are not uniform and provide an inequitable assessment of content, levels of difficultly and scoring practices, which create an irrational basis for any type of interstate endorsements and reciprocity. In two separate state cases, an agency relationship has been determined where a) a testing service administered real estates license examinations, and b) where an examiner designed examinations for licensure, graded examinations, determined who passed and printed state licenses. *Martin v. Educ. Testing Serv.*, 431 A.2d 868, 871 n.7 (N.J. Super. 1981); *Golden Rule Life Ins. Co. v. Mathias*, 86 Ill. App.3d 323, 408 N.E.2d 310 (4th Dist. 1980).

After a review of the "organizational character" of the ABPN, it is apparent that one of its purposes it to "truly protect the public welfare and advancing the interest of justice by reasonably safeguarding the individual opportunity for earning a livelihood while not impairing the proper standards and objectives of the organization. *Treister* (judge dissenting at 396 N.E. 2d 1235.)

The ABPN is not a private body, accepting and rejecting applicants according to its private needs and desires. Rather, it is a guardian of the psychiatry

profession and of the pubic generally. The ABPN holds itself out as the sole board certifying organization in psychiatry and is widely recognized as such. It is a monopoly and it is affiliated with the A.M.A., itself a monopoly, and with numerous medical groups and medical societies.. No one who chooses (and, unsuspecting, trains, and practices) to become a psychiatrist in the United States or abroad can escape its jurisdiction. Therefore the public health is at stake. 396 N.E.2D 1225, 1236 (quoting *Van Daele*, 51 Ill.2d at 395, 282 N.E.2d 728.)

The power of the board, tinged with a public stature or purpose, almost a private, socialized government should not be unbridled, but should be viewed judicia!!y as a fiduciary power to be exercised in a reasonable and lawful manner. *Pinsker*, 1 Cal.3d 160, 165, 81 Cal. Rptr. 623, 460 P.2d 495 (1969) (quoting *Falcone*.)

Last, the Defendants have purposefully gained members in every state of the United States and are responsible for certification, and the future re-certification of members of every state. This process has a substantial impact on every state of the United States. Therefore, this Court should allow the ABPN to become an agent of the state for purposes of allowing this suit to continue.

PLAINTIFFS HAVE PLED A CAUSE OF ACTION FOR DEFAMATION

Under Illinois law, in order to state a claim for defamation the words alleged to

be defamatory must be set forth with particularity. For example, see Letter to Hartke from Scheiber of April 9, 1991. In addition, the Plaintiffs allege special damages and have alleged extrinsic facts which would render the otherwise non-defamatory statements defamatory and actionable. *See* Compl. ¶¶ 32, 45, 86, 101(e).

The statements made by the Defendants which were disseminated to the entire board which alleged that the Plaintiffs were concerned with the Defendant's examination, may reasonably be interpreted as that of a person who is criticizing the Defendant's examination process. (See Ex.F(1)-(3)- Letter from Dr. Maviglia to OMNI Physicians Assoc. of 1/7/91; Letter from OMNI Physicians Assoc. of 3/26/91; Letter from Dr. Scheiber to OMNI of 4/9/91) The words that were disseminated to the alleged "appeal board" citing the Plaintiffs' dissatisfaction with the examination process were "words that prejudiced the Plaintiffs during his appeal. Also, in Illinois, a publication is defamatory per se if it is "so obviously and naturally harmful to the person to whom it refers that a showing of special damages is unnecessary." *Owen v. Carr*, 113 Ill.2d 273, 497 N.E.2d 1145, 1147, 100 Ill. Dec. 783, 785 (1986). However, in order for the statement to be declared as defamatory per se, statements must first be scrutinized under the "innocent-construction rule." Id. This rule requires a court to consider a statement "in context, with the words and implications therefrom given their natural and obvious meaning. *See Chapski v. Copley Press*, 927. Ill.2d 344, 352, 442

N.E.2d 195, 65 Ill Dec. 884 (1982). The Illinois courts basically, have held that if the statement alleged by the Plaintiffs, viewed contextually, "may reasonable be innocently interpreted," then, as a matter of law, the statement is not defamatory per se. *Owen*, 497 N.E.2D AT 1148.

Federal rules also require that a Plaintiff alleging libel or slander should recite the language alleged to be defamatory. *Levitt v. S.C. Food Service, Inc.*, 820 F. Supp. 366, 367 (N.D. Ill. 1993). The Plaintiffs have been identified as "failing candidates" without due process of the law. (For example, *see* Def.'s Mot. to Dismiss at 1.)

PLAINTIFFS HAVE PLED A VIOLATION OF THE ANTITRUST LAWS

To maintain a civil anti-trust action pursuant to Section 4 of the Clayton Act, a plaintiff must meet a two-prong test. Sherman Anti-Trust Act, §§1,2; 15 U.S.C. §2. First, the party must allege injury to his "business or property" within the meaning of the statute, and second, he must allege causation that the injury suffered was occasioned by reason of a violation of the antitrust law.

Plaintiffs must also respectfully request the Court to determine their standing to bring an anti-trust action against the Defendant and request a thorough examination of the allegations contained in the complaint, as well as an analysis of producential consideration aimed at preserving effective enforcement of anti-

trust laws. *See Todorov v. DCH Healthcare Authority*, 921 F.2d 1438 (11th Cir. 1991).

In the case at bar, the Plaintiffs have standing to sue since they have directly, as well as indirectly been injured by the illegal acts of the Defendants.

Plaintiffs need not have a particularly voluminous business in the relevant market in order to have standing to complaint about illegal antitrust activities in the market. 15 U.S.C. §§ 15; See *Southwest Suburban Bd. of Realtors, Inc. v. Beverly Area Planning Ass'n*, 830 F. 2d 1374 (7th Cir. 1987);

Monopoly" is in essence the power to fix price and exclude competition." 15 U.S.C. §2. In order to prove the illegal monopoly by the ABPN of IMG's in violation of the Sherman Act, Plaintiffs contend that the ABPN possesses the monopoly power of psychiatrists nationwide, and that the ABPN has willfully acquisition and/or maintained that power since the early 1930's and has not allowed IMG's board certification. In short, as of June 1993, the ABPN has control of a population of 31,046 psychiatrists in the United States. See Exhibit (Rodrigo A. Munoz, M.D., Commentary, International Medical Graduates Face License and Certification Problems, The Psychiatric Times*Medicine & Behavior (Feb. 1991).

Furthermore, the Plaintiffs allege the advertisement and collection of application fees for the Part II oral examination violates the Sherman Act, based on a theory of monopoly leveraging." (See Exhibits G(1)-(4)-Preliminary Review and Appeal Process for Negative Determination-One

Hundred ($100) Dollars Fee; Preliminary Review of Dr. Maviglia of: 12/13/90; 12/4/91; 12/30/92, 1/4/93) The Plaintiffs allege 1) monopoly power in the relevant market for board certification of psychiatrists by the ABPN; 2) challenged activities in a defined second market, distinct from the ABPN; 3) use of ... monopoly power rather than mere employment of other advantages that the ABPN enjoys by virtue of the size of the number of psychiatrists applying annually for board certification, integration by the number of IMGs, the amount collected by the ABPN consisting of application fees, check-list fees, informal appeal fees, etc. from each applicant (See H(1)-(5)-Letters from ABPN to Dr. Maviglia and Dr. Sanjuan re: receipt of appeal fees; Letters to ABPN re: examination fees) 4) unwarranted competitive advantage in the leveraged marked by the ABPN; and 5) and causal antitrust injury (failure to move from State to State.) *See Catlin v. Washington Energy, Co.*, 791 F.2d 1343 (9th Cir. 1986); *Grayson Electric*, 571 F. Supp. at 1518-19.

Relevant market is essential a question of fact which the Plaintiffs have set forth in their complaint. 15 U.S.C. §§1,2. See Compl. ¶¶ 12, 13, 19, 42, 43.

PLAINTIFFS HAVE MADE A PRIMA FACIE CASE FOR AN ANTI-TRUST CLAIM

The Plaintiffs' met all of the requirements for a prima facie case of Anti-trust claim, the Plaintiffs have stated with particularity, the following: 1) Deliberate and concerted efforts by the Defendants who

have entered the field of psychiatry market into with the specific intent of achieving a monopoly by the ABPN by limiting IMG's from board certification in Psychiatry; and 2) the commission of at least one overt act in furtherance of the conspiracy. Id. at footnote 35.

Private parties, such as the Plaintiffs at bar, are filing this complaint under the antitrust laws function as "private attorneys general" representing the public interest. 15 U.S.C.

Lost profit claims need not be calculated with mathematical precision in anti-trust claims. *IBM Peripheral EDP Devices Antitrust Litigation v. International Business Machines Corp.*, 459 F. Supp. 626 (N.D. Ca. 1978). (Ex. -Rodrigo Munoz, M.D., *From The President: Addressing the Needs and Interests of IMG Psychiatrist/Identifies Areas Where APA Needs to Improve Representation*. supra. ("IMGs are devoted to the care of the poor, the chronically ill, and the homeless in the state hospitals[], federal and municipal hospitals, mental health centers, the poor areas of the big cities, and rural America.)

Evidence of acts prior to Plaintiffs' market entry is admissible to show monopolistic intent. 15 U.S.C. §§1,2. See Compl.¶¶ 12, 13, 42, 43.

Section 4 of the Clayton Act provides, the Plaintiff must show in addition to an antitrust violation: 1) a causal relationship between the antitrust violation and the alleged injury, suffering a "direct

injury" to his business or property as a result of the violation or that he was within the target area of the allege antitrust conspiracy--i.e., a person against whom the conspiracy was aimed.; and 2) damage to his business or property. *See Hawaii v. Standard Oil Co.*, 405 U.S. 251 (1972).

Defendants' impediment of the board certification process of IMGs is a direct antitrust violation of an illegal restraint of trade and an unreasonable burden on interstate commerce and trade. Namely, after years of acquiring a name as a psychiatrist in their profession, the Defendants have now deemed the Plaintiffs a failure. The Defendants have intentionally barred the Plaintiffs from attaining board certification in their area of specialization. Contracts are also examined to see if they violated antitrust laws under one of two standards: whether contract is a per se violation, or whether purpose or effect of the contract is to unreasonable restrain trade. 15 U.S.C. §1. See Compl. ¶¶122, 23.

This Court in determining whether to dismiss this very serious violation of the federal statutes should further consider:

1) The causal connection between the alleged antitrust violation and the harm caused to the thousands of IMGs;

2) The improper motive and intent of the Defendants to "protect U.S. Medical graduates, while impeding the growth of IMGs";

3) Whether the Plaintiffs injuries are sought to be redressed by

antitrust damages;

4) There is a direct correlation between their injury of non-board certification and the actual market restraint and sharp decrease in the board certification of IMGs;

5) The non-speculative nature of the damages claimed by the Plaintiffs See Compl. -Prayer for Relief ¶¶T (a)-(e).

6) The fact that there is no risk of duplicated recoveries by the Plaintiffs or complex damage apportionment since the Defendants have rehabilitated their examination administration process and or declare the Plaintiffs board certified. *See Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*, 635 F. Supp. 1287 ((D. Kan. 1986)

Proximate cause of antitrust injury from violation of antitrust laws can be shown by: causal connection between the violation and injury sufficient to establish violation as a substantial factor in occurrence of damages; and the illegal acts linked to Plaintiffs engaged in activities intended to be protect by antitrust laws.

THERE IS A "DANGEROUS PROBABILITY" OF SUCCESS IN THE PLAINTIFFS' ANTITRUST CLAIM

The Illinois courts has supported and held that in order to establish an attempt to monopolize under Section 2 of the Sherman Act, it is necessary to prove "dangerous probability." *See Lektro-Vend Corp v. Vendo*, 660 F. 2d 255 (7th Cir. 1981, cert denied. 455 U.S. 921 (1982); *American Academic Suppliers, Inc. v. Beckley-Cardy,*

Inc. 922 F.2d 1317, (7th Cir. 1991).

In the case at bar, Plaintiffs have not only shown that there is a "dangerous probability" that the ABPN's attempt to monopolize board certification of psychiatrists, it has actually provided evidence that the ABPN has in fact already monopolized it. (See Exhibits A-D, supra.

THE PURPORTED "HOLD HARMLESS" AGREEMENT THAT PLAINTIFFS' EXECUTED AS PART OF THEIR APPLICATION IS UNCONSCIONABLE

In 1984, the ABPN attained status as a non-profit Delaware corporation, maintaining its principal place of business in the state of Illinois. See Compl.¶ 3. See *McCreery Angus Farms v. American Angus Ass'n*, 379 F. Supp. 1008 (S.D. Ill. 1974) (not-for-profit...must adhere to basic principles of fairness and due process which laymen can understand and administer.)

The Defendants claim they are exonerated from any claims by the Plaintiffs based on a New York State case with a short discussion and no supporting primary or secondary authorities. The Defendants further assert that this Court should rely on *Balaklaw v. American Bd. of Anesthesiology, Inc.*, 149 Misc.2d 11,562 N.Y.S.2d 360 (1990), where based on the execution of an hold harmless agreement by a physician, an intermediate New York state court, barred his action for damages against a certifying board. See Def's. Mot. ¶III.

However, a careful review of *Balaklaw*

provides facts and an analysis which are irrelevant to the case at bar, namely:

Unlike the agreement executed in *Balaklaw's*, the terms of the ABPN's purported hold harmless agreement is cumbersome, burdensome, one-sided and ambiguous to a lay-person. Adequate consideration required for the validity of the agreement should be manifest in the administration and review of the examination. *Balaklaw*, 149 Misc. 2d at 14. However in the case at bar, the administration of the oral examination is so manifestly unfair and grossly imputed with negligent acts of conduct by examiners that there is no adequate consideration. See Comp. ¶¶ 52, 55, 59, 60, 61, 78, 79, 87, 93, 101. Furthermore, the Defendants are not afforded a review of their own examination which would also lend towards the "adequate consideration" required for a parties to execute any hold harmless agreement. See Compl. ¶¶ 22(d), 25, 28, 36, 64, 67, 71, 81, 86, 89, 94, 99, 103.

Also, unlike *Balaklaw*, the case at bar does not lack the "urgency of circumstances" wherein a party may sign a contract under stressful circumstances. The Plaintiffs are in fact dealing with a very stressful situation since the filing of this Complaint, the ABPN has publicly announced that in 1994, it will implement a ten (10) year re-certification process for all board certified psychiatrists who were duly certified prior to 1994. Due to the Defendant's violative and illegal acts, they have caused the Plaintiffs to forego "grandfathering in" their board

certification as for all duly board certified candidates prior to 1994. Therefore, the doctrine of inviolability of the "hold harmless agreement" should be overcome.

Last, in *Balaklaw*, the physician did not meet the minimal threshold requirements for imputing discriminatory treatment by the Board of Anesthesiology since, unlike the case at bar, his examination was a "uniform, standardized written examination for certification."

UNDER ILLINOIS LAW: THE ABPN "HOLD HARMLESS" AGREEMENT DOES NOT PROTECT THE DEFENDANTS FROM SUIT

Under the state of Illinois contract law, the Court should review the requirements of an "hold harmless provision under local law." All "hold harmless" provisions of a contract must be strictly construed against the benefitting party and the intentions of the parties must be delineated with the greatest degree of particularity. *Harris v. Walker*, 119 Ill.2d 542, 519 N.E.2D 917, 919 (1988); *Rayner Covering Systems, Inc, v. Danvers Farmers Elevator Co.*, 226 Ill. App.3d 507, 589 N.E.2D 1034, 1037 (2nd Dist. 1992); *Diedrich v. Wright*, 550 F. Supp. 805, 808 (N.D. Ill. 1982) (quoting *Verwind Corp. v. Litton Industries, Inc.*, 532 F.2d 1, 4 (7th Cir. 1976). In the case at bar, the intentions of the parties were not delineated with the greatest degree of particularity since the Plaintiffs were instructed by the ABPN that they could not take the board certification examination without executing the

Application Statement ("hold harmless agreement"), forthwith. (See Exhibit 1-Application Statement). The ABPN warns all applicants that "unsigned or altered forms will not be processed and will be returned." Therefore, in addition to passage of the FLEX examination, applicants are required to execute the "Application Statement". This last requirement is regardless of the Plaintiffs understanding of the contents since they have are forced to sign it in order to take the board certification examination.

The Illinois Supreme Court has recognized "hold harmless" provisions unless they are a) against the state's public policy, and b) there is something in the social relationship of the parties militating against upholding the agreement. *Jackson v. First Nat'l Bank of Lake Forest*, 415 Ill. 453,114 N.E.2d 721 (1953). *Accord, Raynor*, supra; *Harris*, supra.; *Diedrich*, supra. In the case at bar, the Application Statement is against public policy in that it supports a subjective, biased oral examination. It forces candidates to sign the Statement without allowing any modification for a fairer Statement to both parties. Further the Statement allows fraudulent conduct by the ABPN and its agent. Further the Statement misrepresents the entire examination process since it states in pertinent part: "the Board makes academic and scientific judgments in its evaluation of the results of its examinations..."

A private organization...tinged with public stature or purpose, may not expel or

discipline a member adversely affecting substantial property, contract or other economic rights, except as a result of fair proceeding which may be provided for in organization by-law, carried forward in an atmosphere of good faith and fair play." For over one hundred years, the concept of unconscionability has been recognized in the State of Illinois prior to its implementation by the Uniform Commercial Code §2-102. *Fox v. Kitton*, 19 Ill. 519, 531-532 (1858).

In analyzing the "contractual agreement" between the parties, traditional Illinois conflict of law principles will apply. Basically, where a contract is to be performed in more than one state, the law of the place of execution is controlling. Id. The court should look at the law of the place where the contract was executed in determining the validity, construction and obligations of the contract. *See Boise Cascade Home & Land Corp. v. Utilities, Inc.*, 127 Ill. App. 3d 4, 468 N.E.2d 442, 448 (1st Dist. 1984).

Contracts are usually construed based on the forum state where the contract was executed. In the case at bar, Rafael Sanjuan, M.D., the first named Plaintiff executed the application statement in New York which states, "the basic test of unconscionability is whether in view of the general ...setting and circumstances existing at the time of entering the contract, clauses are so one-sided as to be oppressive and unfair. *Kolentus v. Avco Corp.*, 798 F.2d 949 (7th Cir. 1986). Furthermore, in *Kolentus*, the 7th Circuit

Court of Appeals went on to state, "an unconscionable contract is "characterized by absence of meaningful choice by one of the contracting parties and by contract terms which are unreasonably favorably to the other party. "(See Exhibit I- Application Statement, supra.).

Further, as espoused in *Kolentus*, if the court decided there was no legal contract executed between the parties, unjust enrichment should be recognized. Since the purported "hold harmless agreement" is invalid and unenforceable, the courts would allow the Plaintiffs to recover for unjust enrichment. See Compl.-Prayer for Relief ¶¶ (c). For purposes of the Plaintiff, Rafael Sanjuan, M.D., under New York law, the Plaintiff must show that the Defendant were enriched at the expense of the Plaintiffs under circumstances requiring that in equity and good conscience the Defendants should make restitution." Id. at 959. In the present case, the Defendant continue to be enriched at the expense of Rafael Sanjuan, M.D. under circumstances evincing that of inequitable and illegal tactics.

In *Kolentus*, the basic test of unconscionability under New York law is, "whether, in view of general commercial setting and circumstances existing at time of entering into contract, clauses at issue are so one-sided as to be oppressive and unfair. *See Kolentus v. Avco Corp.*, 798 F.2d 949 (7th Cir. 1986).

In New Mexico, the state where the second named Defendant, Marcello A.

Maviglia, M.D., executed his contract, the federal district court in states that the state of the contract is based on where the consummation by the last signatory. *Brashar v. Mobil Oil Corporation*, 626 F. Supp. 434, 436 (D. Mexico 1984) (quoting *Transradio Press, Inc. v. Whitmore*, 47 N.M. 95, 99, 137 P.2d 309 (1943)) In the case at bar, Dr. Maviglia signed his application in the state of New Mexico.

Like New York, the state of New Mexico interprets a contract based on the language of contract, its purposes and circumstances of its execution in order to determine the intent of the parties. *City of Farmington v. Amoco Gas Co.*, 568 F. Supp. 1265 (D. New Mexico 1983).

Also the Seventh Circuit in *Bentley v. Painter House Co.*, 332 F.2d 107 (1964) stated that in the absence of clear and explicitly language so providing, indemnity, contract will not be construed as indemnifying one against his own negligence." Id. at 110.

The 7th Circuit Court of Appeals in *Communications Maintenance, Inc. v. Motorola* stated, "There are two conjunctive elements of an unconscionability contract claim: substantive, which refers to content of the contract and procedural which refers to circumstances under which the contract wa negotiated and signed." 761 F. 2d 1202, 1209 1985). The content of the ABPN's application statement is fundamentally unfair and contains unreasonable terms and is the product of inequality of bargaining power. Id. This statement is indeed

unconscionable.

In the present case, the court should carefully review the ABPN's purported hold harmless agreement and will undoubtedly find it to be unreasonable with various terms unknown to any party without legal representation.

DEFENDANTS HAVE INTENTIONALLY INTERFERED WITH THE PLAINTIFFS CONTRACT

The Plaintiffs state further, that although they have signed the purported application statement, the Defendants intentional and malicious inducement of that contract resulting in the Defendant's wrongful conduct has caused the Plaintiffs to incur damages. *See Fuller v. Chicago College of Osteopathic Medicine*, 719 F.2d 1326, 1330 (7th Cir. 1983).

DEFENDANTS HAVE CONSPIRED WITH EXAMINERS AND BOARD PREPARATORY COURSES TO IMPEDE THE BOARD CERTIFICATION PROCESS OF IMGs.

Plaintiffs have provided statistical information in support of their contention of the discriminatory impact of the ABPN's board certification Part II oral examination. (See Exhibit B, supra.) *See N.Y. Transit Authority, v. Beazer*, 440 U.S. 568, 584 (1979); *Hazelwood Sch. District v. United States*, 433 U.S. 299, 307-8 (1977); *League of United Latin American Citizens v. City of Santa Ana*, 410 F. supp. 873, 891 (C.D. Ca. 1976) It is apparent that the

ABPN and Scheiber have intentionally chosen to impede the board certification process of IMGs, the Plaintiffs are prepared to prove a pattern and practice by the ABPN of discrimination for at least a decade.

In Illinois, a disproportionate impact alone may suffice to make out an adequate claim of discrimination, but only if there is other strong evidence that exclusion of group discriminated against was systematic. The Plaintiffs allege that the Defendants, by setting an arbitrary and capricious grading scheme of their Part II oral examination process, have unlawfully discriminated against the Plaintiffs on the basis of their status as IMGs. It is further alleged that there is a disparity between the passing rates of U.S. medical school graduates and IMGs. See Ex. - Statistical Breakdown of Board Certified Psychiatrists in the United States (1993)).

In the United States Supreme Court case, *Washington v. Davis*, the Court held that impact alone may suffice to make out an adequate claim, but only if there is other strong evidence that the exclusion of the discriminated group was systematic. 426 U.S. 229, 239 (1976). Also the Plaintiffs' allegations of discrimination by the Defendants is not unsubstantiated. See compl. ¶¶27, 28, 40, 66, 85, 100, 101, 103. See Exhibit. A-C.

A prima facie case of discriminatory treatment is established by showing that, a) the Plaintiffs are graduates of International Medical Schools (formerly Foreign Medical Schools), and that b) they

in no way failed the examination, (See Exhibit J(1)-(2)-Marcello A. Maviglia, M.D.-Formal Appeal of 1/7/91 and 1/92, respectively) (See Exhibit K-Rafael Sanjuan, M.D.-Formal Appeal of 2/1/93), and c) that despite their qualifications, received an arbitrary and capricious grade from the Defendants, and d) that after notifying the ABPN of their erroneous grading of the Part II examination (See Exhibits L(1)-(1)(2) - Letters from Dr. Maviglia to the ABPN of 6/5/91, 1/29/92), the ABPN failed to review their examination and sustained the failing grade without meeting their burden of proving the Plaintiffs failure by a preponderance of the evidence.

THE ABPN HAS FAILED TO TREAT ALL CANDIDATES ALIKE AND THEREFORE HAS VIOLATED THE EQUAL PROTECTION CLAUSE OF THE FEDERAL CONSTITUTION

The recertification process of Psychiatrists who become board certified after February 1994 will result in the discrimination of thousands of IMGs who have not been allowed to pass the Part II oral examination. This recertification requirement is not rationally related to any state interest in that all other psychiatrists will attain lifetime certification.

The Equal Protection Clause of the United States Constitution requires that all similarly situated persons be treated in a similar manner. *See Cleburne v. Cleburn Living Center, Inc.* 473 U.S. 432 (1985). During the Part II oral examination and subsequent grading and review process, the

ABPN has not treated all psychiatrists in a similar manner. The APBN has made distinct differences in the treatment of U.S. Medical Graduates and IMGs. The classification between U.S. Medical Graduates and IMGs serve no legitimate public interest. *See Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 465-66 (1981); *Oriental Health Spa v. Fort Wayne*, 864 F.2d 486, 490 (7th Cir. 1988). The ABPN's separation of graduates is not rationally related to the advancement of any state interest.

In order to establish violation of the Equal Protection Clause, the Plaintiffs have provided evidence of invidious discrimination against IMGs in favor of U.S. Medical graduates with no rational basis for the differentiation in the treatment.

The Equal Protection Clause of the Fourteenth Amendment of the federal Constitution requires only that the Court determine whether the classification bears a rational relationship to a permissible governmental purpose for the ABPN to "treat persons similarly situated alike." U.S. CONST. amend. XIV. The permissible governmental purpose in treating IMG's like U.S. medical school graduates was expressed in "landmark legislation" protecting international medical graduates [IMGs], who in 1992, made up twenty-five (25%) percent of the physicians in the United States." (See Ex. - American Medical Association, International Medical Graduates (Jan. 1993).

For years, the treatment of IMGs by the Defendants have been the subject of criticism. (See Exhibits (A) and (C),

supra.-Rodrigo Munoz, M.D., Commentary, *International Medical Graduates Face License and Certification Problems*, The Psychiatric Times-Medicine & Behavior (Feb. 1991); Rodrigo Munoz, M.D., From The President [APA], *Psychiatric News*, Sept. 18, 1992, at 3.

Based on the foregoing, the Court should not dismiss Plaintiffs' claims for a cause of action under the constitutional principles of equal protection.

Pursuant to Section 1983, an action will lie only where there has been, under color of state law, a "deprivation of any rights, privileges or immunities secured by the Constitution and laws." Further' Section 1985(3) prohibits a conspiracy to deprive, either directly or indirectly, any person or class of person of the equal protection of the laws or of equal privileges and immunities under the laws. In Defendants' motion to dismiss, they state that a corporation cannot conspire with itself. However, in the case at bar, the Defendants are not conspiring with themselves but with examiners and the ABPN, the fiduciary and the ABPN, the board of directors and the ABPN and anyone else who will assist in barring the board certification process of IMGs

PLAINTIFFS HAVE PLED A PRIMA FACIE CASE OF FRAUD

Pursuant to local law, all averments of fraud shall be stated with particularity. In compliance with Rule 9(b) of the Federal Rules of Civil Procedure, Plaintiffs'

complaint contains the date, place and manner of the false representations or actions of the Defendants. *See also Tamera v. Gait*, 511 F. 2d 504, 508 (7th Cir. 1975). It further identifies the parties involved and the consequence of the misrepresentations. See Compl. ¶¶ 62, 64, 67, 79, 81, 89, 93, 94, 98.99, 101,102,103, 105. In short, for the past twenty (20) years, the ABPN has utilized a subjective oral examination to bar IMGs from obtaining board certification. However, even more importantly, the ABPN provides an Applicant Statement setting forth "acceptable" behavior for board candidates which is fact is a fraudulent. See Compl. 22, 23.

Additionally, the Defendants assert and misrepresent that "failing board candidates" may obtain a preliminary review of their "failing examination." However, the purported review is only a "check-list" of the sub-categories allegedly failed by candidates. The Defendants further misrepresent that for fees ranging from close to Eight Hundred ($800) Dollars, a "failing candidate" will receive a formal review of their "failing examination." However, the Defendants collect exorbitant fees without reviewing examinations.

The Defendants misrepresent that a candidate will have his examination reviews. Only after contacting the ABPN to check on the status of their appeal are candidates then given a cursory denial of their grade.

The Defendants misrepresent that the examination will be graded by competent examiners. During every examination, the

examiners fell asleep, interrupted the Plaintiffs and conducted their own personal business, appeared fatigued, and/or lacked the obvious educational requirements of an examiner. The Plaintiffs have set forth the basic outline of the scheme of fraud perpetrated by the Defendants, who made what misrepresentations and the general time and pace of such misrepresentations. *See Darling & Co. v. Klouman*, 87 F.R.D. 756, 757-58 (N.D. Ill. 1980).

Pursuant to law of Illinois, a Plaintiff must prove that a Defendant made false statement of material fact, and not of opinion, knowing they were false, intending that Plaintiff rely on them, that Plaintiff did rely, that reliance was justified and that Plaintiff was damaged thereby. *West v. Western Casualty and Surety Co.*, 846 F.2d 387 (7th Cir. 1988); *General Motors Acceptance Corp. v. Central Nat'l Bank*, 773 F.2d 771,778 (7th Cir. 1985).

The Plaintiffs have set forth statements of the Defendants that relate to past and present facts of fraud during the examination process. (See Exhibits J and K, supra.) The Defendants publicized their board certification examination results and sent the names of failing candidates to board "preparatory" courses. The Plaintiffs were justified in relying on the Defendants since they [the ABPN] are the only board certifying authority in the nation. As a result of the Plaintiffs' reliance, they have been made worse off than had there been no fraud on the part of the Defendants, *Stromberger v. 3M Co.*, 990 F.2d 974 (7th Cir. 1993). First, the Defendants are in

jeopardy of losing lifetime board certification and being subjected to re-certification and additional fees and costs. Second, the Plaintiffs have lost large sums of monies in the process of trying to obtain board certification. See Compl. ¶29, 30, 31, 50, 54 65, 75, 77, 80, 82, 95, ¶.

Under Illinois law, common-law fraud may be proven by: 1) a false statement of material fact which the Defendants have made throughout the examination process beginning with the Defendants' Instructions to Candidates and culminating in the purported formal appeal of "failing candidates; 2) knowledge or belief of the falsity by the party making it which the Defendants have full knowledge of; and 3) the Defendants' intention to induce the Plaintiffs to submit an exorbitant application fee, and subsequent "appeal" fees.

Further, the Defendants contend the Part II board examination is based on a fair administration of the examination by trained examiners. However, the Plaintiffs allege that the administration of the examination is subjective, as well as fraudulent in that the Defendants have conspired with board preparation courses to pass candidates who take certain courses. Additionally, many of the "live patients" utilized during the actual administration of the examination have already been viewed and assessed by candidates who take certain board preparatory courses.

The definition of fraud as expressed in *Gibbons v. Brandt*, is" [I]t includes anything calculated to deceive, whether it

be a single act or a combination of circumstances, whether suppression of truth or suggestion of what is false, whether it be by direct falsehood or by innuendo, by speech or by silence, by word of mouth or by look or gesture. 170 F.2d 385 (7th Cir. 1948). See Compl. ¶¶$9, 60, 78, 93, 101.

Further, Scheiber who acts in the fiduciary capacity as the executive director of the ABPN has represented himself to be...trustworthy and an expert on the ABPN's exam administration process. Pursuant to Illinois law, once a party who is not an expert accepts the offer and reposes complete trust in the first person, as the Plaintiffs did with Steven Scheiber, M.D., then a fiduciary relationship has been established. *Burdett v. Miller*, 957 F.2d 1375 (7th Cir. 1992).

PLAINTIFFS HAVE PLEAD FRAUD, INCLUDING MAIL FRAUD

Pursuant to federal statute, mail fraud proscribes different conduct and requires proof of different elements from false statements. 18 U.S.C. §1001. *See United States v. Weatherspoon*, 581 F.2d 595, 599 (7th Cir. 1978) (submission of false student enrollment cards to the Veteran's Administration.) But *see United States v. Craig*, 573 F.2d 455 (7th Cir. 1977) (The use of mails by defendant in furtherance of scheme renders scheme to defraud amenable to federal jurisdiction and thus the mailings are jurisdictional element of offense of mail fraud, pursuant of 18 U.S.C. § 1341.)

Additionally, the Defendants'

fraudulent acts have invalidates their purported contract and will be affirmatively established by clear and convincing proof of each and every essential element of fraud. *See Classic Bowl v. AMF Pinspotters, Inc.*, 403 F.2d 463 (7th Cir. 1968).

The Defendants state that in the Plaintiffs' complaint, there has been no averments of fraud made with specificity. This is an incorrect statement. The Plaintiffs in the present case have made numerous references to the Defendants' malicious acts, intentional acts, and knowledge of said acts were made generally. However, the actual fraudulent acts were made with specificity. *Quantum Overseas, N.V. v. Shearson Lehman Hutton, Inc.*, No. 89C7914, 1990 WL 114480 (N.D. Ill. July 31, 1990.); *Guest v. Balmes*, 1989 WL 97839, No. 89 C 20006 (N.D. Ill. July 11, 1989).

Furthermore, the Plaintiffs have included references to the approximate date on which the fraudulent schemes occurred, the subject matter of the scheme, the parties involved and the content of the alleged fraudulent statements pursuant to F. Rule Civ. Proc. 9(b); *Milosevic v. Ferrari*, 1990 WL 7089, No. 89C2955 (N.D. Ill. Jan. 19, 1990.)

Last, as a result of their fraud claim, the Plaintiffs have requested punitive damages. *See Darling & Co. v. Klouman*, 87 F.R.D. 756, 759 (1990) (punitive damages may be awarded in appropriate fraud actions.)

CONCLUSION

The Plaintiffs' complaint should not be

dismissed because Illinois law does not preclude Plaintiffs from bringing this action under the "economic necessity" requirement expressed in *Treister*. In fact, Illinois law encourages the Plaintiffs to bring this action against the Defendants for their "wrongful acts" in violating the local laws.

Furthermore, the "release agreement" violates pubic policy under Illinois law and is unconscionable under the laws where each contract was executed.

Last, based on the counter-arguments contained in this Supplementary Memorandum of Law and the Plaintiffs first Memorandum of Law in Opposition to the Plaintiffs' Motion to Dismiss, the Plaintiffs respectfully request that the Court test the sufficiency of their Complaint and construe the Complaint's allegations in the light most favorable to the Plaintiff. Plaintiffs have proven a set of facts in support of their claims that would entitle them to relief. As expressed in *Conley v. Gibson*, 355 U.S. 41 at 45-46. the Complaint has alleged facts sufficiently setting forth the essential elements of each count.

WHEREFORE, for all of the foregoing reasons, Plaintiffs respectfully request that the Court grant their motion allowing this supplementary Memorandum of Law to supplement their response filed on December 3, 1993 with this Court, and that the Court deny Defendant's motion and allow Plaintiffs' complaint, and this action to go forward without prejudice.

Dated: December 10, 1993

Respectfully submitted,

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